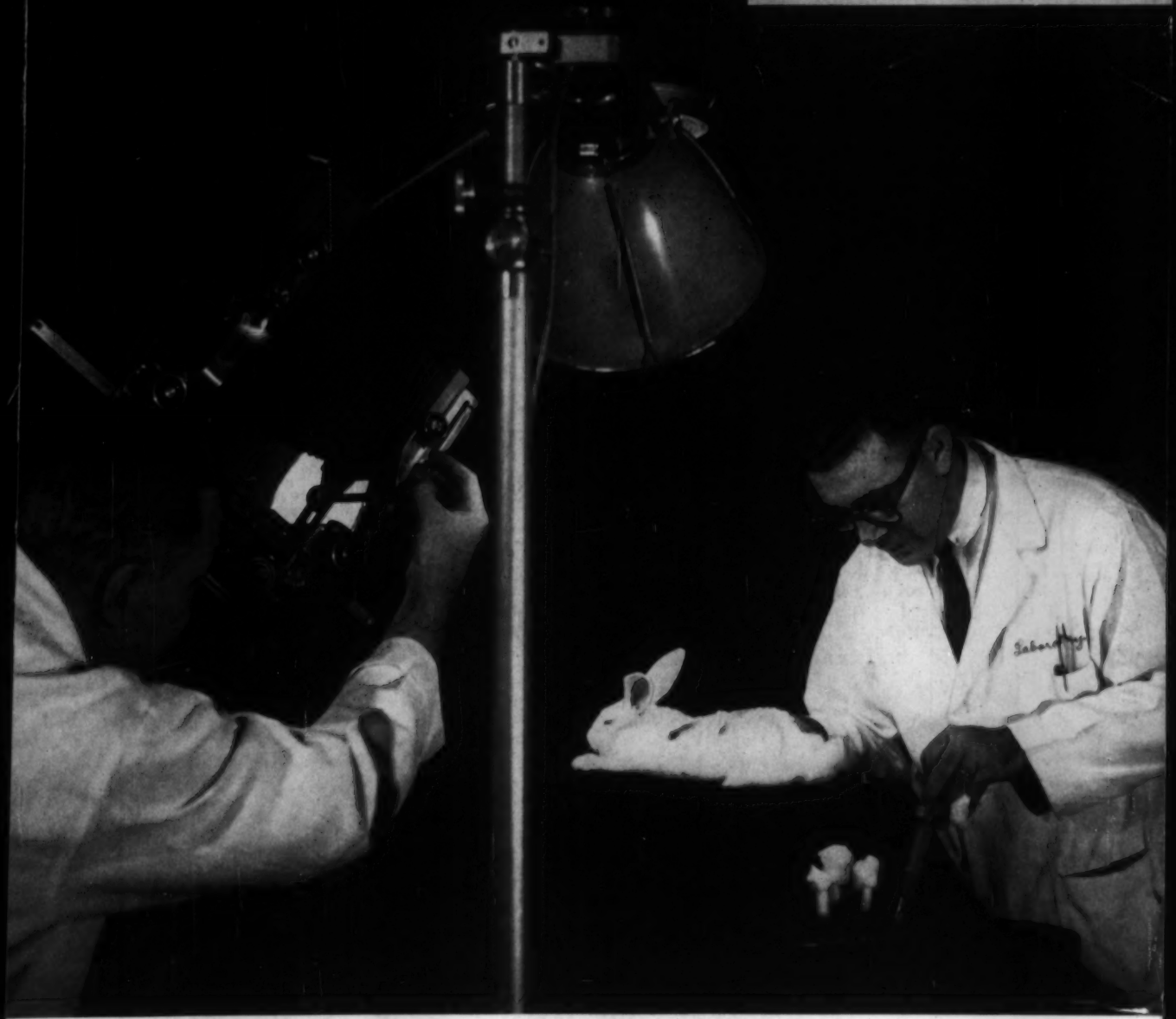
HOSPITALS

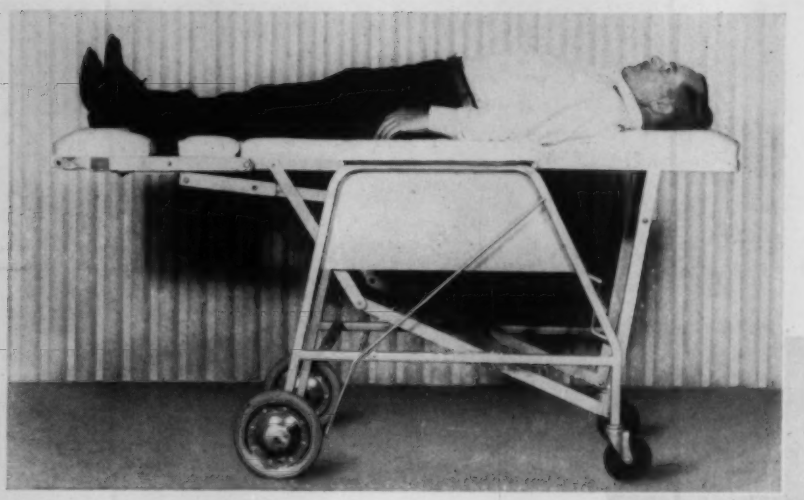
JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

JANUARY 16, 1958



PHOTOGRAPHY IN THE HOSPITAL (page 45)

Special Section on Hospitals and Poison Control



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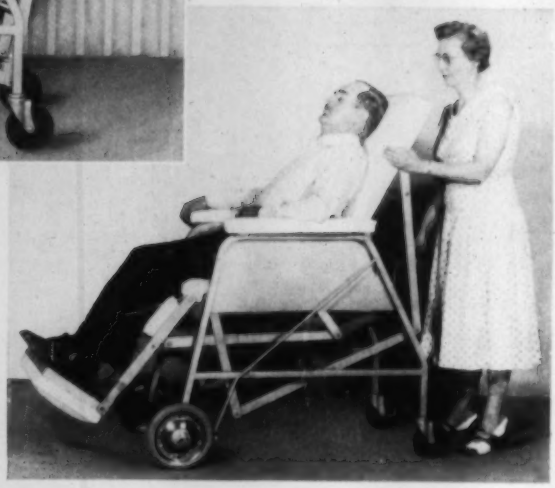

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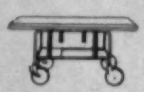

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articles

Hospitals and Poison Control: A Special Section
Poison Control Centers — George M. Wheatley, M.D. — 38
First Aid Measures for Poisoning — 40
National Clearinghouse for Poison Control Centers — Howard M. Cann, M.D. — 42
Four Views of a Visual Aid Department — Martin Saren and Sidney Shapiro — 45
What the Community Expects of the Hospital — Nathan Stark — 50
Caring for the Terminally Ill — Ellen Saunders — 56
Duties of the Purchasing Agent in Planning for Disaster — William Slabodnick — 62
A Practical Approach to Lower Laundry Costs — Robert Guy — 74
How to Prepare Dietary Budgets for Large Hospitals — Grace L. Scholz — 78

departments

Food Service and Dietetics — 78
Laundry-Housekeeping — 74
Professional Practice — 56
Purchasing — 62

regular features

Accreditation Problems — Kenneth B. Babcock, M.D. — 26
Association Section — 54
Book Reviews — 88
Calendar of Association and Allied Meetings — 8
Digest of News — 17
Editorial Notes — 37
Equipment and Supply Review — 69
Introducing the Authors — 12
News — 97
Opinions and Ideas — 28
Personnel Changes — 90
Pro Re Nata — John H. Hayes — 109
Service from Headquarters — 22
Washington Report — 94

cover

Animals involved in laboratory procedures at Long Island (N.Y.) Jewish Hospital are often camera subjects of the hospital's visual aids department. An article discussing the uses of visual aids in both clinical and nonclinical functions at the hospital starts on page 45. Photo by staff photographer at Long Island Jewish Hospital. (Other picture credits on page 112.)

Classified Advertising — 110
Index to Advertisers — 112

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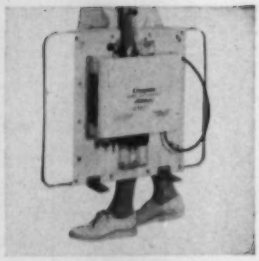

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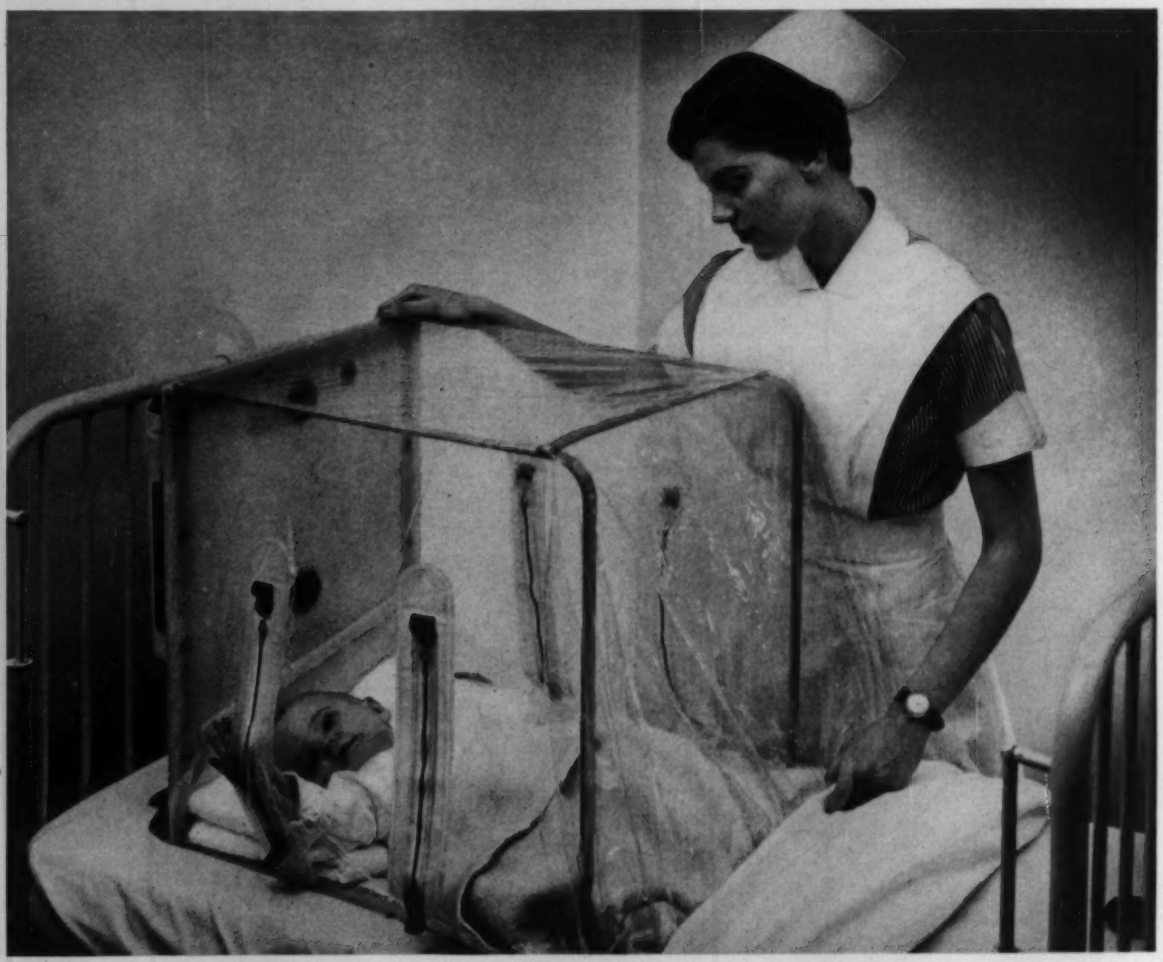

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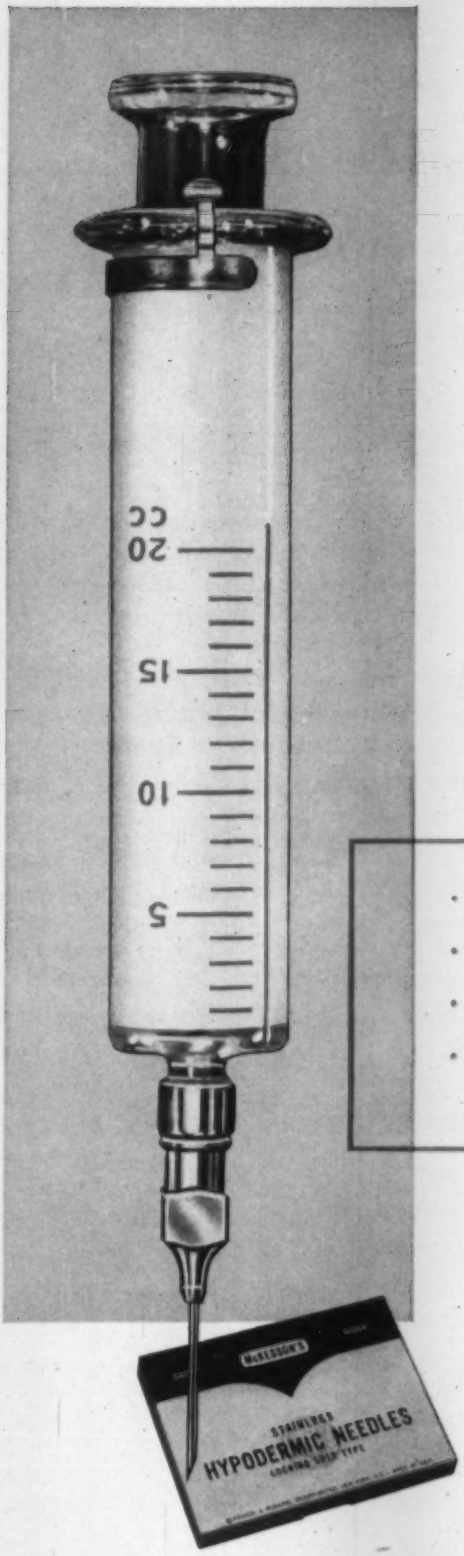

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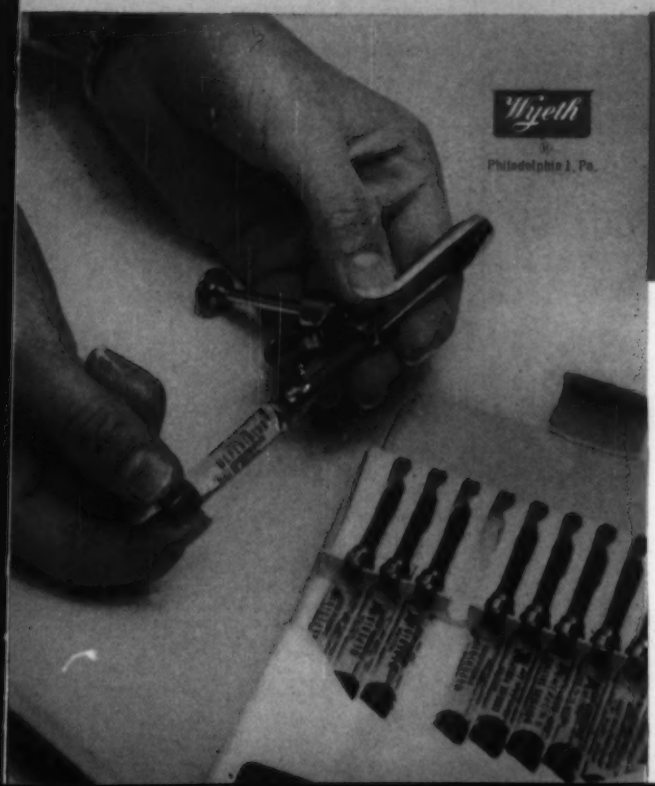
1. Hunter, J.A., et al.: Hospital Management *83*:86 (March) 1957.



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American Hospital Association
1958 Annual Convention — August 18-21; Chicago (International Amphitheatre; Palmer House)
1959 Annual Convention — August 24-27; New York City (Coliseum; Statler Hotel)
1960 Annual Convention — August 29-September 1; San Francisco (Civic Auditorium)

(THROUGH DECEMBER 1958)

American Hospital Association Midyear Conference of Presidents and Secretaries—February 7-8; Chicago (Palmer House)
American Protestant Hospital Association—February 11-13; Chicago (Morrison Hotel)
Catholic Hospital Association—June 21-26; Atlantic City, N. J. (Convention Hall; Dennis Hotel)
National Association of Methodist Hospitals and Homes—February 11-13; Chicago (Morrison Hotel)

REGIONAL MEETINGS

(THROUGH DECEMBER 1958)

Association of Western Hospitals—April 21-24; San Francisco (Civic Auditorium; St. Francis Hotel)
Carolinas-Virginias Hospital Conference—April 24-25; Roanoke, Va. (Hotel Roanoke)
Maryland-District of Columbia-Delaware Hospital Association — Nov. 3-5; Washington (Shoreham Hotel)
Middle Atlantic Hospital Assembly — May 21-23; Atlantic City, N. J. (Convention Hall)
Mid-West Hospital Association—March 24-26; Kansas City, Mo. (Municipal Auditorium; President Hotel)
New England Hospital Assembly—March 24-26; Boston (Statler Hotel)
Southeastern Hospital Conference—May 14-16; Miami Beach, Fla. (Hotel Fontainebleau)
Tri-State Hospital Assembly—April 28-30; Chicago (Palmer House)
Upper Midwest Hospital Conference—May 14-16; Minneapolis (Minneapolis Auditorium; Leamington Hotel)

STATE AND PROVINCIAL MEETINGS

(THROUGH JUNE 1958)

Alabama Hospital Association—January 30-31; Tuscaloosa (Hotel Stafford)
Connecticut Hospital Association—June 11; Berlin (Berlin Light and Power Company)
Georgia Hospital Association—February 20-21; Columbus (Ralston Hotel)
Iowa Hospital Association — April 24-25; Des Moines (Savery Hotel)
Kentucky Hospital Association — April 15-17; Louisville (Sheraton-Seelbach Hotel)
Louisiana Hospital Association—March 20-22; Baton Rouge (Bellemont Motor Hotel)
Maine Hospital Association — June 10-11; Rockland (Samoset Hotel)
Massachusetts Hospital Association — May 15; Boston (Hotel Statler)
Michigan Hospital Association — June 16-18; Mackinac Island (Grand Hotel)
New Jersey Hospital Association—May 21-23; Atlantic City (Convention Hall)
New Mexico Hospital Association — March 9-12; Albuquerque (Hilton Hotel)
Hospital Association of New York State—May 21-23; Atlantic City, N. J. (Hotel Claridge)
North Dakota Hospital Association — April 22-23; Fargo (Gardner Hotel)

(Continued on page 104)

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introducing the authors

George M. Wheatley, M.D., suggests activities, coverage and basic texts that community hospitals may use in establishing a poison control center in his article in the Journal's special section on hospitals and poison control beginning on p. 38 of this issue. Dr. Wheatley has had the opportunity to gain a clear insight into the problems and preventive measures for effective poison control in his capacity as third vice president for health and welfare of the Metropolitan Life Insurance Company and as chairman of the American Public Health Association's Committee on Chemical Poisons.

DR. WHEATLEY

During his chairmanship of the American Academy of Pediatrics Committee on Accident Prevention (1952-55), Dr. Wheatley closely examined the high death rate among children from accidental poisoning. In his article Dr. Wheatley reports the committee found that children under five years of age account for approximately three-tenths of the poisoning fatalities and for 75 per cent of the nonfatal cases treated at poison control centers.

Dr. Wheatley's interest in pediatrics is of long standing, for the Harvard University medical school graduate chose pediatrics as his area of specialization. Following his internship at Hartford (Conn.) Hospital, Dr. Wheatley served as pediatric house officer at Harriet Lane Home at Johns Hopkins Hospital. He continued his work in pediatrics in New York City as research fellow at Postgraduate Hospital and as assistant in pediatrics at New York Hospital.

In addition to his medical degree, Dr. Wheatley holds a master of public health degree from Columbia University.

Active in many national health and medical groups, Dr. Wheatley is currently a member of the governing council of the American Public Health Association and of the executive board of the American Academy of Pediatrics. He is also chairman of the section on pediatrics of the American Medical Association.

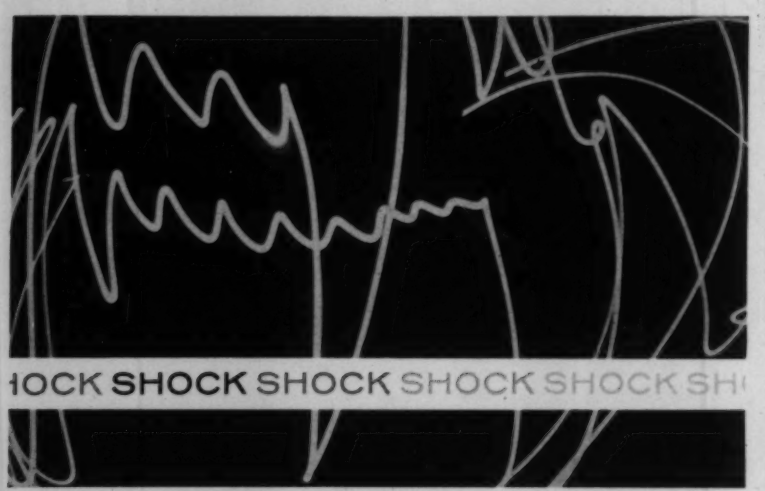
Dr. Wheatley's professional affiliations include fellowship in the American Academy of Pediatrics, American Board of Preventive Medicine and the New York Academy of Medicine.

Howard M. Cann, M.D., director of the National Clearinghouse for Poison Control Centers, Washington, D. C., describes the services and future plans of the Clearinghouse in the second article in the special section on hospitals and poison control on pp. 38-44 of this issue. Organized in November 1956, the National Clearinghouse classifies and distributes information on poisons or potential poisons to local poison control centers and helps set up new centers.

DR. CANN

Prior to his appointment last August as director of the Clearinghouse, Dr. Cann was completing his residency work in pediatrics. He took his first year of training in pediatrics at the University of Colorado Medical Center, Denver, and his second year at Stanford University Hospital, San Francisco. Dr. Cann received his medical degree in June 1954 from the University of Colorado Medical School and served a rotating internship at San Francisco Hospital on the University of California teaching service.

Dr. Cann is licensed to practice medicine in Colorado and California. He is a diplomate of the National Board of Medical Examiners.



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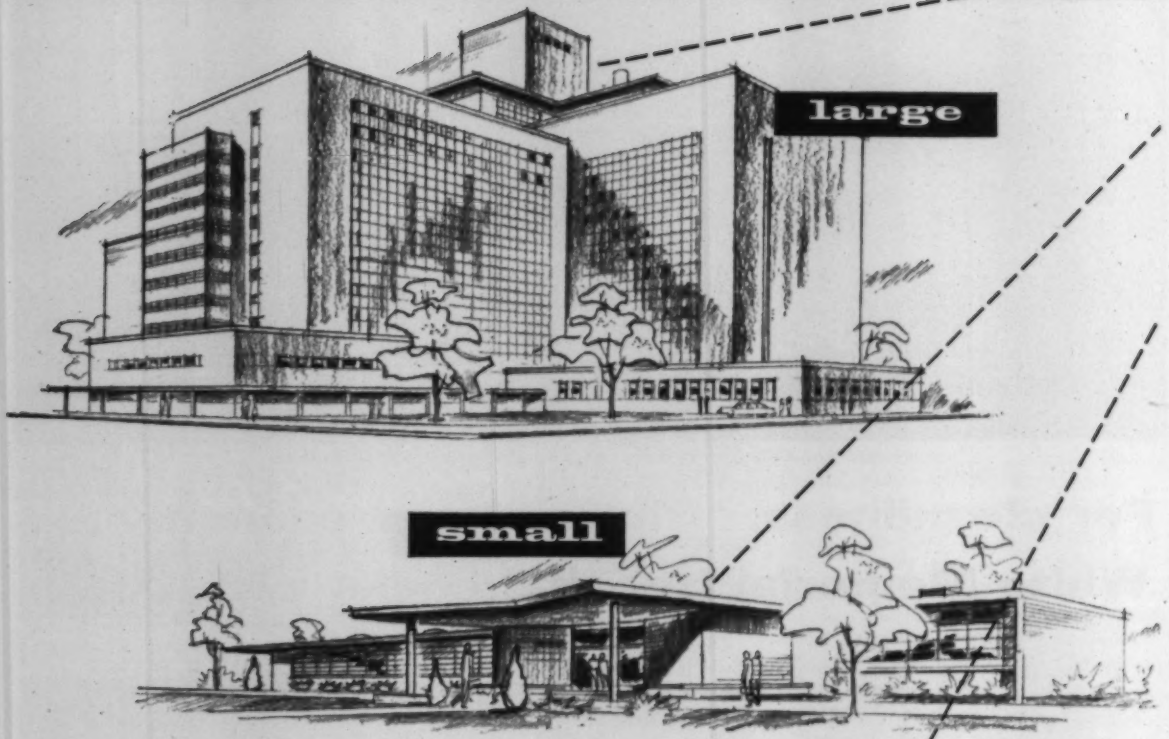

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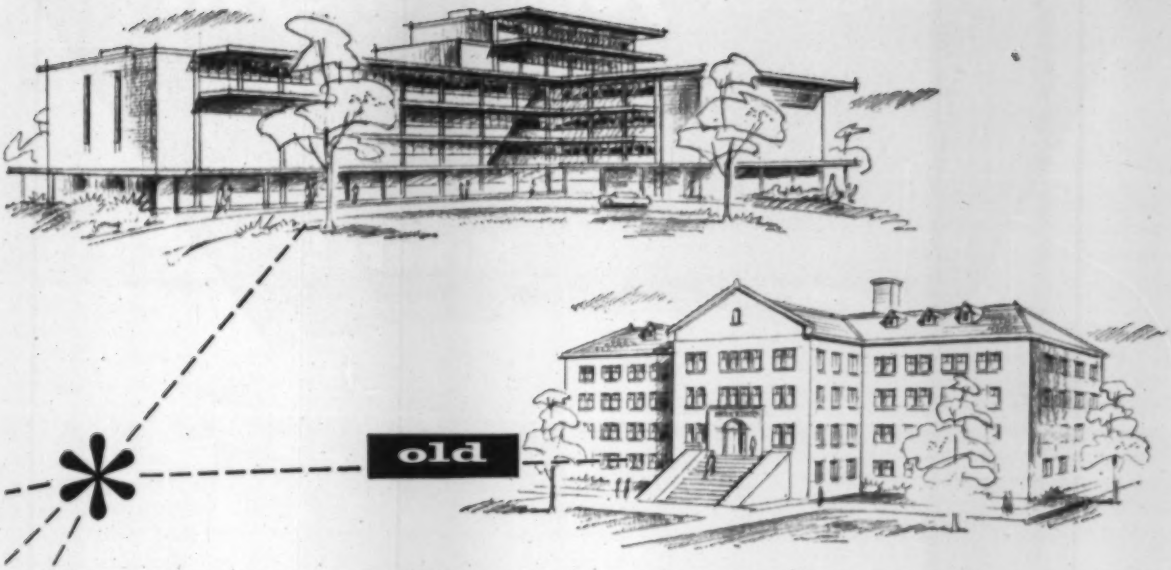

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REPORT FROM WASHINGTON—The second session of Congress convened on Jan. 7 in Washington.

President Eisenhower's State of the Union message was to be read to Congress on Jan. 9. Congress must have his proposed budget for the coming fiscal year before Jan. 22.

Knowledgeable congressional leaders feel that relatively little attention will be given to health and hospital projects because of Congress' preoccupation with the forthcoming elections and the economic problems provoked by Russia's recent military and scientific accomplishments. Details p. 94.

• A program to expand the number of skilled health science researchers — the General Research Training Grants Program —has been established by the Public Health Service. Details p. 94.

• A resolution calling for a 10-year extension of the Hill-Burton hospital construction program has been approved by the American Federation of Labor-Congress of Industrial Organizations. Details p. 96.

• "Medicare" officials have revised the regulations governing the use of ward facilities in hospitals. Details p. 96.

• One hospital and five convalescent or nursing homes, all operated for profit, received loans in November 1957 from the Small Business Administration. Details p. 96.

• Construction contracts totaling nearly $900,000 have been authorized by the Public Health Service for the improvement and expansion of Indian hospital and housing units. Details p. 96.

• Sumner G. Whittier has been sworn in as administrator of veterans affairs, succeeding Harvey Higley who resigned recently.

Mr. Whittier is the first Veterans Administration head to be appointed from within the agency and, at 46, is the youngest man ever to hold down this post. Before his appointment Mr. Whittier was VA's chief insurance director and was in charge of some 5000 employees.

Prior to joining VA Mr. Whittier was lieutenant governor of Massachusetts and the Republican gubernatorial candidate in that state in 1956.

• An estimated 1.3 million persons are employed in U. S. hospitals, more than in many of the country's largest industries, a report from the Department of Labor stated.

• Seventeen hospital construction projects are awaiting final government approval to be the first hospitals to get federal loans for student nurse and intern housing.

• Grants totaling more than $300,000 have been made by the Public Health Service as part of its nation-wide research program directed toward the development of preventatives for cerebral palsy, mental retardation, and related neurological disorders.

The participating institutions are Charity Hospital, New Orleans, and Columbia University, New York City. They received $168,167 and $150,000 respectively. Eleven other medical centers participating in the studies have received grants totaling approximately $2.1 million during the past 18 months.

NORTH CAROLINA GROUP SURVEYS HOSPITAL ADMISSION RATES—A direct relationship exists between the hospital admission rate of a given group and the economic level of that group. So reported the North Carolina Health Council after studying the elements affecting general hospital facility use in the state. Details p. 97.

NEW YORK NURSE SCHOOLS OPERATING BELOW CAPACITY: SURVEY—As of May 1957 there were 8829 student nurses in 215 New York State hospital schools of professional nursing, according to a survey conducted by the Committee on Nursing Service and Education of the Hospital Association of New York State.

Total capacity of these schools is approximately 14,300.

Of the students registered in the schools replying to the survey, 3292 were in the freshman year, but the freshman capacity in these schools is approximately 4764.

Recruiting new students, inadequate housing facilities, and a faculty shortage were cited as the major reasons for the schools' operating at below capacity. Most of the hospitals replying to the survey stated that they were in favor of training male nurses, but few schools presently accept them or have plans to do so.

Nineteen hospitals reported plans to begin schools of nursing—9 for registered nurses and 10 for licensed practical nursing. Twenty-nine schools of professional nursing also reported plans for expansion of their facilities.

GRADUATE NURSING PROGRAM GRANTED $238,000—Duke University has been given a $238,000 grant by the Rockefeller Foundation to

Worth Quoting

". . . Nothing must replace patient care as the primary goal of good administration. The hospital which consistently bases its program on caring for patients will be rendering a valuable service long after the 'gimmick' institutions have fallen in usefulness. If hospital administration is to prosper as a profession, the abiding principle of good patient care must precede every consideration of price, popularity, promotion, and politics . . . "—Austin J. Evans, *administrator, Hadley Memorial Hospital, Hays, Kans., in a speech at the American Hospital Association convention, Atlantic City, N. J., Oct. 3, 1957.*

support a new graduate program in nursing.

The grant, extending over a period of seven years, will supplement more than $200,000 in Duke University funds allotted for the program.

Five students are presently enrolled in the course which offers a master of science in nursing degree after 12 months of study. The program centers around development of advanced nursing skills to better equip nurses for specialized responsibilities in hospital bedside nursing, for supervisory positions, and for teaching.

Duke University School of Nursing Dean Ann M. Jacobansky said that the shortage of well-trained nurses is becoming more acute at a time when hospital beds in the state are rapidly increasing (see separate story p. 98).

▸ TWO HOSPITAL CARE IMPROVEMENT PROGRAMS ANNOUNCED IN MICHIGAN—"YOU, the Ambassador," a year-long program to encourage hospital employees to strive for better relationships with patients, visitors, and others with whom they come in contact, has been inaugurated by the Michigan Hospital Association.

The packaged program for hospital employee education consists of:

A booklet, *YOU, the Ambassador*, to be distributed to each employee.

- A series of monthly two-color bulletin board posters carrying out the program's theme and dealing with various aspects of courtesy, good conduct and consideration for patients.
- Suggested employee materials for use in administrative memoranda, paycheck attachments, and employee publications.
- News releases and other material to assist in publicizing and extending the program.

Michigan's hospital association and Michigan Hospital Service (Blue Cross) are cooperating in another improvement program—this one to find ideas that have saved money and improved service in hospitals.

Some $4000 has been set aside by the two groups for 15 prizes to be awarded to hospital employees who submit written reports of the best new ideas they have developed and tested in member hospitals of the Michigan Hospital Association.

First prize is $1000. There are also to be 4 awards of $500 each and 10 awards of $100 each.

▸ HOSPITAL CONSTRUCTION INCREASE REPORTED—Associated General Contractors of America, in a year end statement, reported that construction activity in 1957 reached a grand total of more than $65 billion, breaking records for the 12th consecutive year.

Private hospital and institutional construction rose more than 50 per cent to a volume of nearly $500 million. Moderate increases were registered in public hospital and institutional activity.

▸ INHALATION THERAPISTS REVISE MEMBERSHIP STANDARDS—The American Association of Inhalation Therapists has ruled that applicants seeking membership in the association must be high school graduates, have equivalent education, or have equivalent on the job training. The new ruling became effective Jan. 1.

new style **POST-OPERATIVE STRETCHER** *with* **DUAL CRANK CONTROL by** J&J

one crank positions the litter
another crank positions the back rest

"Easier and safer for my patient—and much less work and effort for me."

Handle mechanism is color-coded for quick identification of desired position.

J & J post-operative stretchers protect the patient and simplify the work of the nurses. The 3-position litter crank makes it possible to raise or lower the litter to the position required in a few seconds, with no uncertainty or delay.

The new back-rest crank permits rapid Fowler positioning. The back support is securely geared to stay rigid in any position between flat and maximum elevation. The crank is hinged and spring-loaded and is not in the way when not in use.

For full information write for new J & J stretcher brochure.

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the *Theme* pediatric room by Simmons

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Easy-to-care-for Simmons cribs are chrome-plated steel to resist strong, young teeth and the banging of hard toys. Positive catches keep youngsters in bed where they belong. Simmons cribs are available in five sizes for children of all ages.

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Theme unit furniture, designed by Raymond Spilman, A.S.I.D., permits an almost endless variety of combinations to meet every room plan. Your Simmons Agent or nearby Simmons office is always ready with advice based on nationwide hospital experience.

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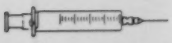

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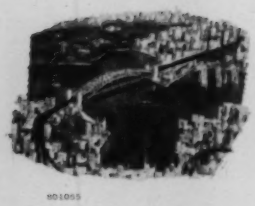
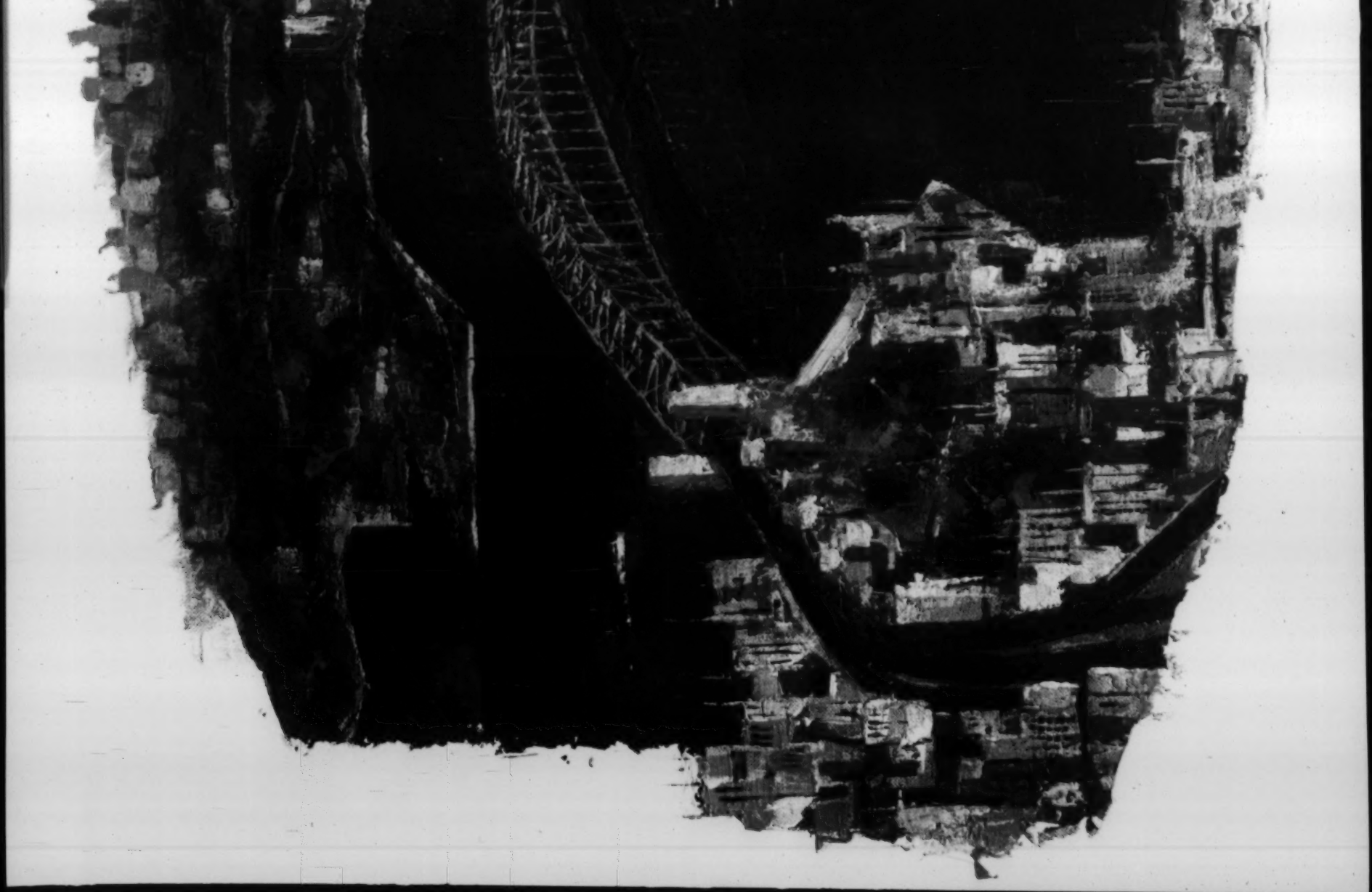


Sydney, Australia by Tom Dunnington. A reprint of this painting on heavy stock, suitable for framing, may be obtained by writing for "Sydney" to: Professional Services, Abbott Laboratories, North Chicago, Illinois.



Sydney, Australia by Tom Dunnington

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801002

B.F.Goodrich develops new surgical glove that reduces hand fatigue, fits comfortably without binding

"Surgiderm" is first glove to have ideal combination of comfort, sensitivity, strength

A new rubber glove, just developed by B.F.Goodrich, is so much more comfortable than other surgical gloves that it has to be tried to be believed. It's softer, more pliable. It fits easily, snugly; doesn't bind the hand or restrict the freedom of the fingers. The difference is so obvious you can feel it just by putting this new B.F.Goodrich "Surgiderm" glove on one hand and comparing it with any other glove on your other hand.

It's the use of a newly-developed rubber compound that makes possible —for the first time—this ideal combination of comfort, sensitivity, and strength in one glove.

Less tiring to the hands

Comparison tests prove that the B.F. Goodrich "Surgiderm" glove is 30 to 50 per cent softer than any regular rubber surgeons' glove, including the brown cement type. Because it's softer and more flexible, it takes 25 to 30% less force to flex the fingers and hand, a tremendous factor in reducing fatigue.

More sensitive touch

The new glove is extremely sensitive to the touch, responsive to even the slightest movement of the fingers. It is tissue thin, and uniformly thin—no heavy ends at the fingertips.

Stronger, longer lasting

Despite its softness and thinness, this B.F.Goodrich glove is strong to start with and stays strong even after many sterilizations. It is 36% stronger than a brown cement type glove *before* use, 67% stronger *after* ten sterilizations. What's more, it keeps its elasticity, can be stored for months with no danger of deterioration.

Have this test made

Ask a surgeon on your staff to make a comparison test during an operation. Have him wear a "Surgiderm" glove on one hand, any other brand glove on his other hand. We think he'll be convinced that this new glove is the most comfortable he's ever worn.

Where to buy

The new B.F.Goodrich gloves are made in sizes from 6 to 10, have rolled wrists which fit snugly over the gown, are brown in color. They're sold by hospital supply houses and surgical dealers everywhere. *Hospital and Surgical Supplies Dept., B.F.Goodrich Industrial Products Co., Akron 18, Ohio.*

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service from headquarters

Separate facilities for medical-surgical patients

We are anticipating moving into a new wing which will contain several adult bedrooms. In our present hospital building, the medical patients have been housed as much as possible on a floor separate from surgical patients. This separation lends to inflexibility in bed assignment. What are the reasons for separation? If separation is advisable, is there a standard ratio used in general hospitals?

Separating medical from surgical patients is not practiced today as much as it has been in the past. Inasmuch as it is considered good practice to segregate these patients, the tendency has been to construct hospital rooms on a smaller scale than before. All patients in one room should be of the same category of either medicine or surgery so that an 8-10 bed room would necessitate tying up this number of beds for one category of patient. The tendency toward smaller rooms has allowed greater flexibility.

Therefore, there would be both medical and surgical patients on a unit or ward of the hospital and the separation would be by room only.—J. R. ANDERSON, M.D.

Consulting staff selection

Our chief of medicine asked for and was given the privileges of reading electrocardiograms. Does this automatically place him on the consulting staff?

There is absolutely no reason why the physician who has been designated as the interpreter of electrocardiograms should automatically be placed upon the consulting staff. As a matter of fact, such a designation of the interpreter of electrocardiograms is the exception, not the rule.

The simple fact that a physician on the staff reads electrocardiograms does not make him a consultant any more than the pathologist or radiologist who interprets the pathological specimens or the x-rays respectively, providing these latter two are not placed on the consulting staff for other reasons.—J. R. ANDERSON, M.D.

New ownership may affect social security coverage

Does a change of ownership of a hospital affect the social security coverage which it has elected for its employees?

A change of ownership may under some circumstances terminate the social security coverage of employees of a hospital, and require the filing of a new certificate by the new owner if coverage is to be continued.

A case came to our attention recently in which a publicly-owned hospital was transferred to a nonprofit organization, and only some months later was it discovered that social security coverage had terminated at the time of the transfer, with the result that employer and employee taxes paid thereafter had been paid erroneously, and that the social security wage credits of employees for the period after the transfer were cancelled. The same thing could happen without a change of ownership of the property, if there is a change in the identity of the employer—as, for example, if a publicly-owned and operated hospital should be leased to a nonprofit organization for operation by it.

Whenever a hospital which has elected social security coverage for its employees is about to go through a reorganization which will involve a change in the identity of the body responsible for its operation, it would be well to consult the District Director of Internal Revenue to determine whether any action by the new operator is necessary for the continuance of social security coverage. If action is necessary, its timing may also be important.

—ALANSON W. WILLCOX

Wool blankets and infections

Is it necessary to wash wool blankets after each patient leaves the hospital?

The American Hospital Association has not formulated a recommendation in this regard. One of the best sources of reference on this subject is an article by B. R. Frisby M.D., "Cleansing of Hospital Blankets" published in the *British Medical Journal*, August 31, 1957.

The following information is taken from this article which is a report of a project to determine the infectious property of wool blankets before and after laundering. In essence, the article states that wool blankets laundered in the usual manner retain a certain amount of infectious material, specifically staphylococcus aureus. The amount of infection was found to increase after each use. The article also indicates that even after the blankets were sterilized sufficiently to kill the pathogenic organisms they were soon reinfected when put into use. The conclusion indicates that where wards are infected with staphylococcus aureus the blankets become an excellent carrier for this organism which could then be transmitted from the first to all succeeding patients using the blankets. In summary, the article states in part, "hospital blankets unless specially laundered are bacterially contaminated and potentially dangerous."

This article indicates that wool blankets whether laundered after each use or not are a health hazard unless the blankets receive a special sterilization treatment. Method of accomplishing such treatment might be obtained from the blanket manufacturer.

As an alternate solution to this problem the elimination of wool blankets should be considered. Possibly cotton blankets or blankets made from material which can be boiled or subjected to high temperatures such as sheets receive when ironed, could be substituted.—GERALD A. WEIDEMIER

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.

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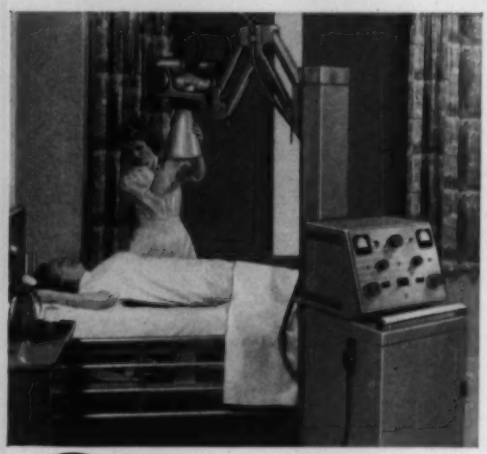

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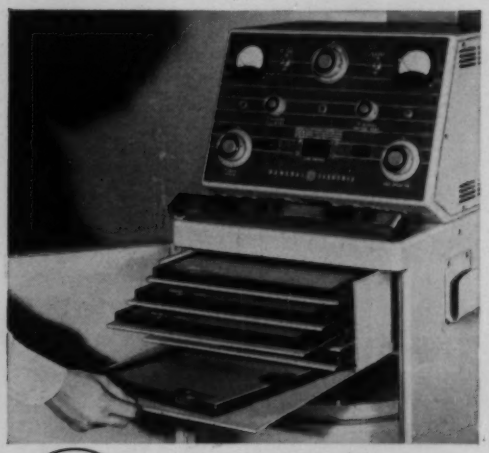

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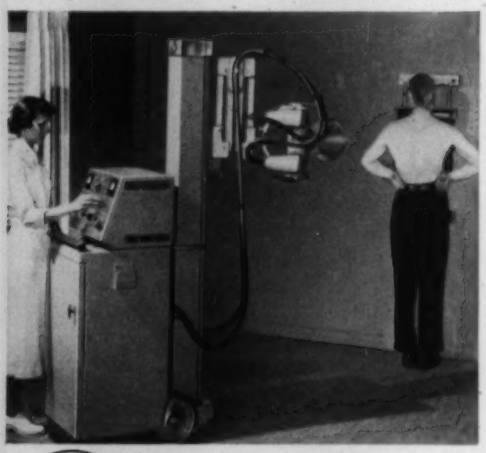

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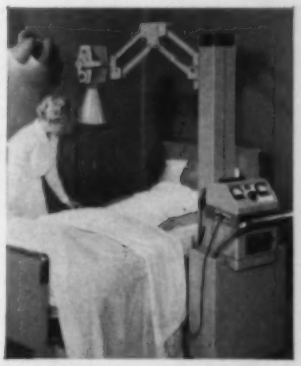
FIND out how the Mobile "200" can help you improve quality of service and expedite case handling. Let your G-E x-ray representative show you how the "200" can serve your particular requirements. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. L-11.



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YOUR NAME TITLE

accreditation problems

KENNETH B. BABCOCK, M.D.

- definition of consultation
- fathers in the delivery room

My staff doctors feel that a frozen section by the pathologist or a pelvimitry by the radiologist should be counted as a consultation. Likewise, when the obstetrician calls in a pediatrician to take care of the baby, is this a consultation?

The answer to these questions is generally no, although under certain circumstances the answer could be yes. Perhaps an explanation of what the Joint Commission considers a consultation would be helpful. A consultation is a definite request for help or advice. A consultation must also consist of a personal, definite, direct examination of the patient and the patient's chart, with a written report rendered.

The mere reporting of a test, even though it is very conclusive and decisive, is not a consultation. If the physician on the case asked the pathologist or radiologist to consult with him, to examine the patient and to render an opinion, and then utilized his tests as part of the consultation, this would be a consultation. The mere referring or transferring a case from one physician to another can never be construed as a consultation.

Newspapers have recently carried stories concerning the presence of the father in the delivery room at the time of the birth of the infant. Several staff doctors have questioned me as to our hospital's policy on the matter. What is the stand and ruling of the Joint Commission on this question?

The Commissioners of the Joint Commission on Accreditation of Hospitals are interested in proper controls, rules and regulations being set up in each hospital concerning such matters. We do not wish to have a single arbitrary rule covering it.

If the hospital made the ruling "no fathers allowed in the delivery room", our surveyors would check to see that it is carried out. If a hospital medical staff votes to allow the father's presence (if he wishes), it is the duty of our surveyors to be sure that proper written rules and procedures have been formulated and are being carefully carried out by the parties concerned.

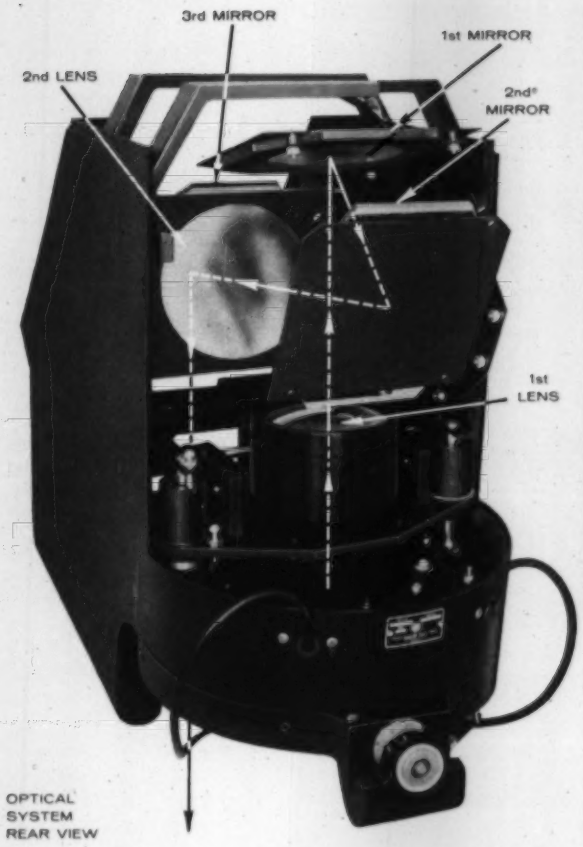
A hospital allowing a father in the delivery room has assumed an additional responsibility. In addition to instructing personnel on procedures, the hospital must see that each father is instructed as to the rules, techniques and procedures that he must observe. Some state laws and local health laws actually forbid the father's presence in the delivery room as well as all other persons not directly or professionally concerned with the delivery. Before adopting any such procedure, local and state laws should be checked.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 660 N. Rush St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

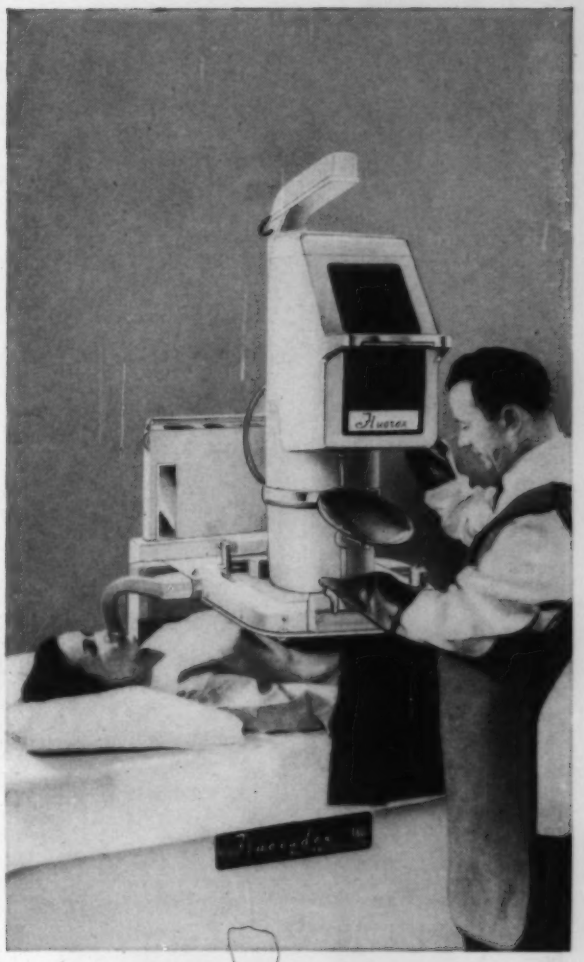
STANDARDS FOR THREE DEPARTMENTS

Standards of the Joint Commission on Accreditation of Hospitals for three important departments of the hospital are featured in the December 1957 issue of the JCAH *Bulletin*. The issue lists standards for the pharmacy and dietary departments and for emergency service.

Although every hospital listed by the American Hospital Association received two copies of the Bulletin, one for the chief of staff and one for the administrator, a limited number of copies of the December issue are available from the Joint Commission, 660 N. Rush St., Chicago 11, Ill. It is necessary that a prepaid payment of 10 cents per copy accompany each request.



OPTICAL SYSTEM REAR VIEW



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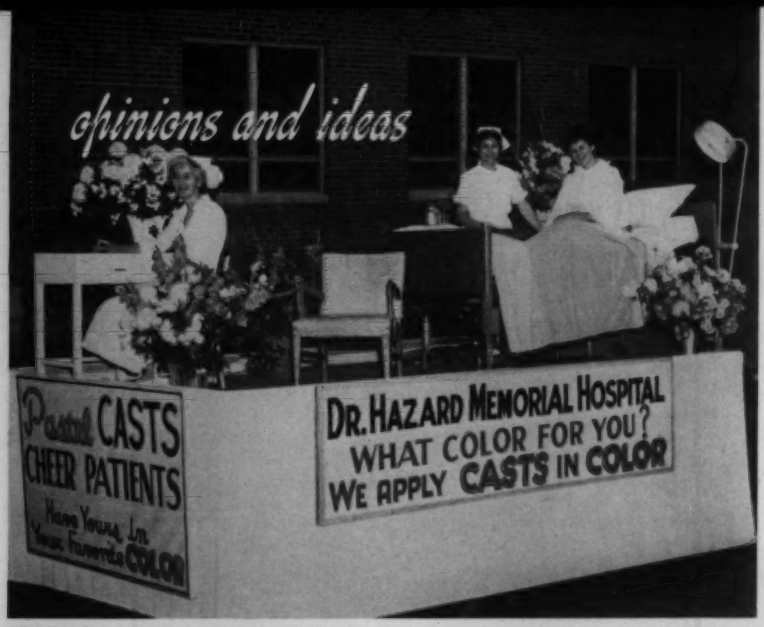
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DEPICTING a hospital room complete with patient in rose-pink leg cast and nurses in attendance, the float (above) was judged the most original entry in the 1957 Mardi Gras parade sponsored by the Exchange Club of Long Branch, N. J. The entry was made by the 48-bed Dr. Hazard Memorial Hospital in Long Branch, which introduced colored casts last May.

'Choose your color' casts cheer patients

As a means of injecting a little color into the unglamorous experience of waiting for a fractured limb to heal, patients at Dr. Hazard Memorial Hospital, Long Branch, N. J., may choose their casts in shades of rose, blue, yellow, and flesh. The colors can also be intermeshed to form a pattern.

Helene K. O'Brien, the hospital's public relations director, reports the "pastel-hued casts have been a great morale builder and conversation piece since their introduction at the hospital last May. Our doctors, moreover, have found that the colored casts are a psychological aid in distracting children by giving them a choice of color."

The color is impregnated in the plaster of Paris and the casts are applied in the same manner as the conventional white cast. "The new casts are not only more cheerful," reports Mrs. O'Brien, "but they do not soil as quickly." This eliminates the need for the patient to return to the hospital for application of additional layers, which only increase the weight of the cast. ■

Toy fair held for parents of handicapped children

To help parents, doctors and other persons who work or live with handicapped children to select toys that will be suitable for them, the St. Louis Society for Crippled Children held a community toy fair in cooperation with a large St. Louis department store. More than 300 persons attended the week-end fair at the society's center in November 1956. The fair was an outgrowth of the society's research study on toys in collaboration with the American Toy Institute Research Division of the Toy Manufacturers of the U.S.A.

Toys on display included those which have therapeutic value for all handicapped children and those found suitable for children with

HANDICAPPED children examine some of the toys displayed at the toy fair sponsored by the St. Louis Society for Crippled Children. The fair was held to help parents of handicapped children select toys that not only will amuse their children but will have therapeutic value for them.

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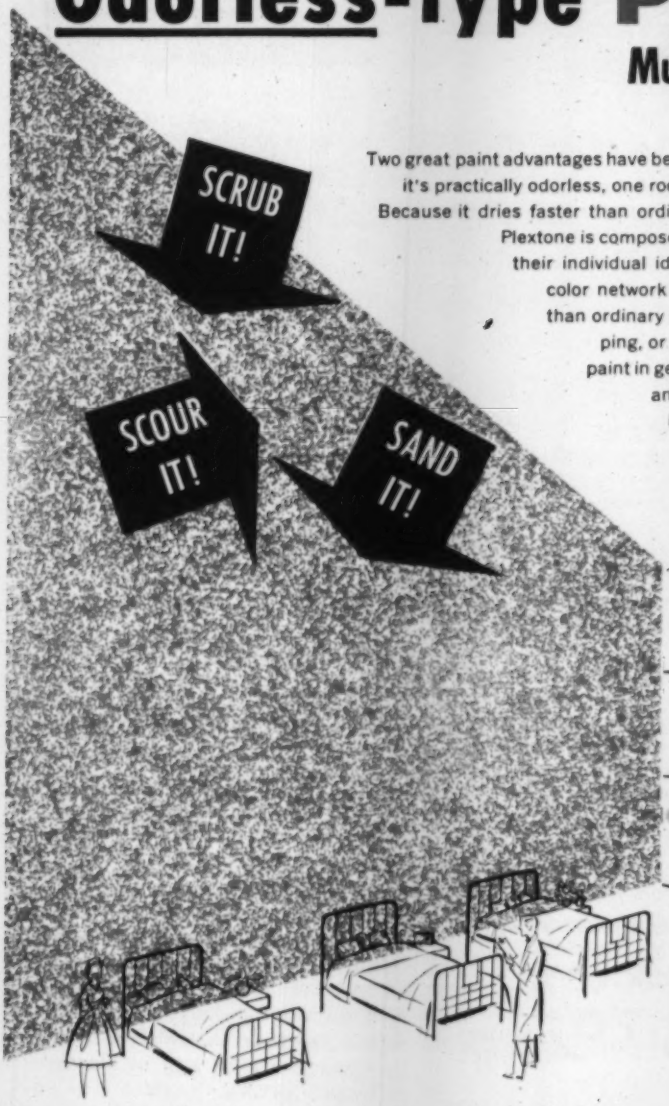

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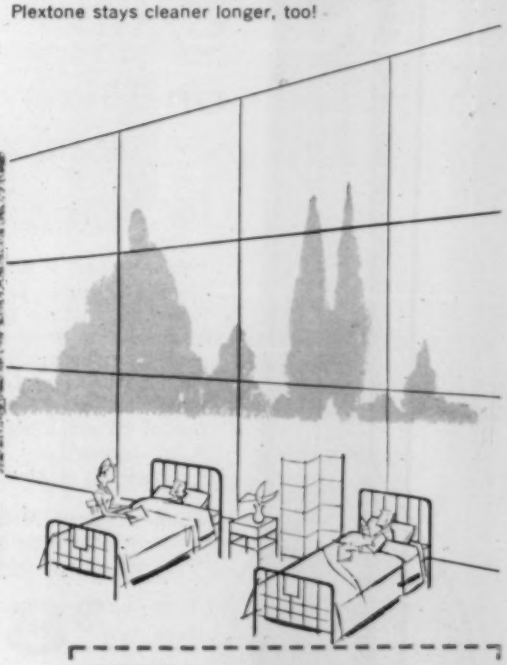

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severe and multiple disabilities. The toys were grouped for the exhibit on the basis of functional activities rather than by age or sex. Physical and speech therapists, nursery school teachers, and other professional personnel from the center's staff were on hand to answer questions.

To publicize the fair, the society prepared a flyer for mailing to parents of children treated at the center, and to clinics, hospitals, and professional schools of physical therapy, occupational therapy, speech, social work, and nursing. Private and special schools in the St. Louis area were also notified. News releases and radio and television spot announcements were prepared and one St. Louis newspaper ran a feature article on the fair.

In evaluating the fair, John H. Kniest, executive director of the St. Louis Society for Crippled Children, reports the "staff felt the plan should be continued, but under a different format." He stated in the future consideration would be given to extending the exhibit over a longer period of time, perhaps in a downtown department store, in an effort to attract a larger audience. ■

Recruitment flyer features work, leisure opportunities

Vancouver General Hospital in Vancouver, British Columbia, like all other hospitals, from time to time experiences severe shortages in the nursing staff. The shortages give rise to critical problems, particularly where a hospital the size of Vancouver General is concerned. This teaching hospital has an overall occupancy potential of 1663 with a school of nursing that graduates the largest number of professional nurses in Canada.

To minimize these nurse staffing problems, the hospital conducts a continuing program of nurse recruitment. Various brochures and other public relations techniques are used, but the most recently developed one, *An Invitation to Nursing*, has met with an unusual degree of success, reports J. N. Robertson, public relations director of Vancouver General Hospital.

The brochure includes a listing of graduate nurse personnel policies and a brief history of the hospital and its school of nursing as well as the city and the province where it is located. Mr. Robertson reports that the brochure was developed so that if professional personnel in cities distant from this province were considering a change of locale, decision as to which nursing opportunity to accept could well be influenced by the opportunities for an expression of cultural interests and leisure time activities as also opportunities for nursing service. The brochure, therefore, highlights the province, in which is located Vancouver, the site of Canada's largest general hospital. The information is supplemented by a series of photographs of the hospital and points of interest in the province.

"Not only has the brochure provoked a very satisfying response," reports Mr. Robertson, "but it has also aroused quite a bit of curiosity about Vancouver and the province." ■

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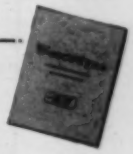

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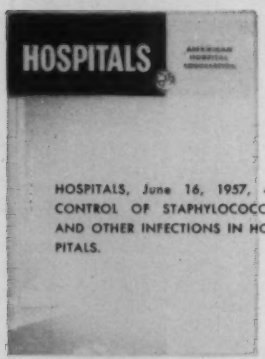

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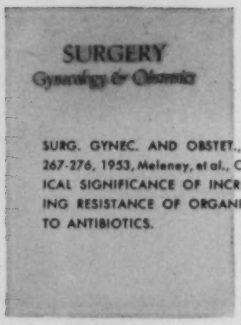

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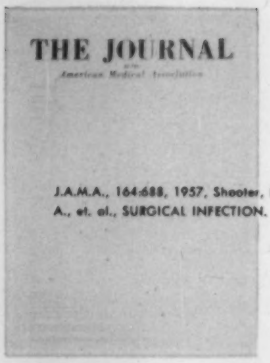

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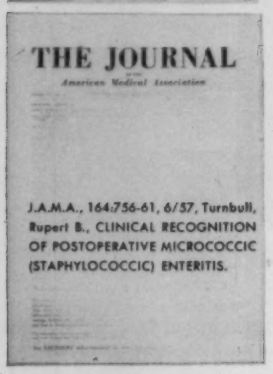

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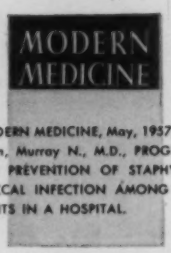

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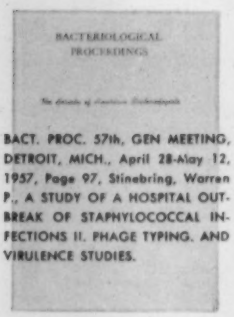

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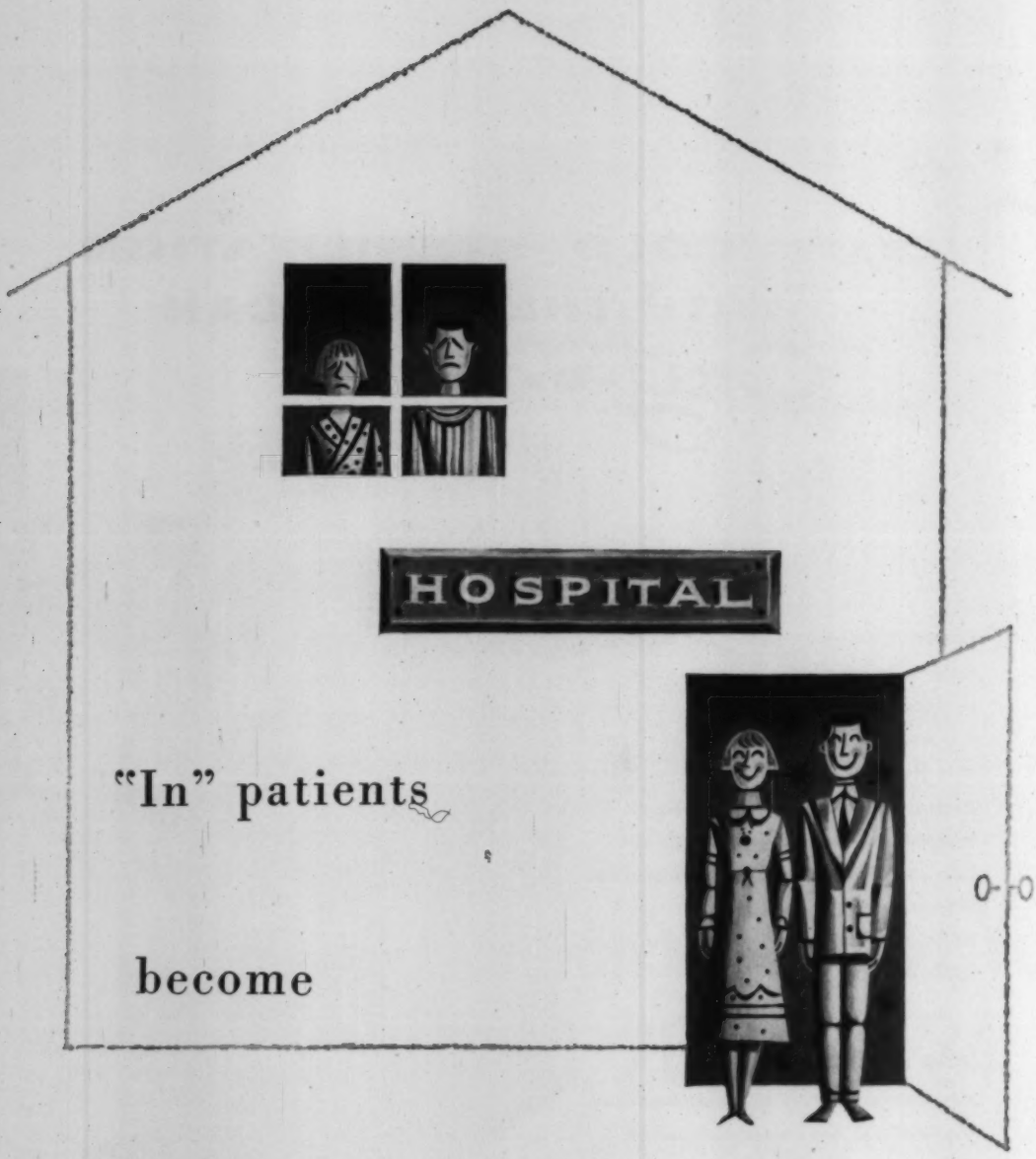

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editorial notes

guest editorial by Robert H. Parrott, M.D.

—*the poisoning control concept*

In our day of mass public appeals for funds for medical causes, a pronouncement that there are as many as 2083 deaths in one year due to accidental poisoning, could be considered of low dramatic value. Isn't a disease such as cancer, or cystic fibrosis, or heart disease worse? True, accidental poisoning figures can be dramatized by computing that there are 89,761 man-years lost due to poisoning deaths in one year. The problem may also be pointed up by saying that there are as many as 100 times as many poisonings as there are deaths due to poisoning. Nonetheless, the statistics—even as they improve—do not tell the whole tale. The important and sad fact is that each one of these deaths and illnesses is capable of being prevented! None of them need to have occurred!

It is possible to oversimplify the problem of accidental poisoning in children to a discussion of three elements:

The Child: A child in the age group most susceptible to poisoning will, by his very nature, try anything once. He is learning, exploring, trying, reaching, climbing, tasting; and if a toxic substance is within the day's wanderings he will try it too. Even older children are inquisitive and will by nature "test the rules" or taste something that looks good or smells good.

The Poison: If the child is to be poisoned, a potential poisonous substance must be available to him. Conversely, poisoning will not occur if such material is safely locked or kept out of his reach. Toxic materials are not only made available to children but are often dressed up in taste, color, and container to render them more attractive, as for example, the candied antipyretics or the furniture polish kept in a soft drink bottle.

The Environment: The child who has ingested a poisonous material cannot be considered apart from his environment. It is failure of environment—failure of parental control—which permits the child to gain access to the poison. In most instances this results from carelessness or ignorance of facts about the behavior of children or the potential toxicity of certain materials.

The ultimate object of any poisoning control program is prevention, to separate the child from potential poisons through his parents; but treatment, pooling of treatment information, research, and educational promotion are vital parts of the concept. Any well functioning program must make its services available to all physicians, health personnel, and medical facilities in an area. This also means, however, that such individuals and facilities must *share* the concept and cooperate with the program. It is suggested that the poisoning control concept can prevail and be truly effective only if each individual physician, health officer, hospital administrator, hospital pharmacist, whether or not he is directly connected with a formal program, will consider that he is responsible for his own poisoning control program.

The physician might inspect the medicine cabinets of his patients as he makes home calls. The health officer should be sure that his department is offering proper case follow-up, public information and laboratory services. The administrator should be sure that his outpatient service is properly equipped to manage accidental poisoning cases. The pharmacist should be sure that he has a reasonable file of poisoning information, and that he is labelling his prescriptions to "keep out of the reach of children".

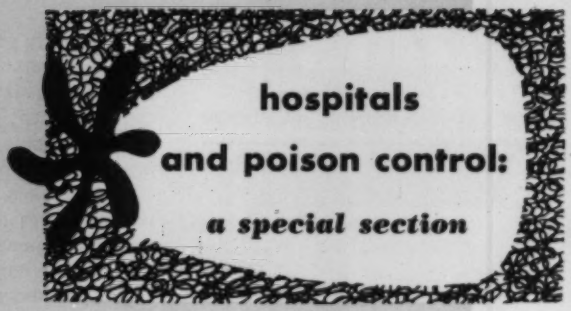
In brief, accidental poisoning is preventable. Basically the problem is to keep the child away from potential poisons. All have a stake in the problem and each of us can help by practicing the poisoning control concept within his own scope of activities.

—*a role rewarded*

In most communities, the hospital is a sizable employer. It buys services; it buys products. For these and other expenses, hospitals in this country this year will spend approximately $6 billion. In so doing, they will contribute significantly to the financial as well as physical well being of the communities they serve.

The hospital's economic role, however, is often overlooked in the light of the more dramatic services it performs in keeping a community healthy. That is why it is heartening to see increased recognition being given by civic groups to this important facet of a hospital's community service. One such instance recently involved the Barberton (Ohio) Citizens Hospital, honored this year by the Barberton Chamber of Commerce as the local industry which had contributed the most to the betterment of the community. Barberton Citizens Hospital, like other hospitals similarly honored throughout the country, deserves our congratulations.

Robert H. Parrott, M.D., is physician-in-chief, Children's Hospital, Washington, D.C.



poison control centers

- *who sponsors them*
- *how they save lives*
- *how hospitals can help*

by GEORGE M. WHEATLEY, M.D.

"JOHNNY'S JUST swallowed a glassful of my hair wave solution. What shall I do?" The physician on duty in the emergency room who hears this anxious young mother's plea over the phone needs to know a lot of things fast. Is the product swallowed toxic? In what amount? What is the name of the preparation? What chemicals does it contain? What is the antidote?

The author gives specific suggestions as to the activities, coverage, and basic texts necessary for a community hospital interested in establishing a poison control center.

Until recently, and unless he had had wide experience with chemical poisoning, the physician had to do the best he could without always being certain of the answers. The problem has become increasingly complex in the past few years because of the growing number of new chemical preparations for household use. Fortunately, in a growing number of hospitals today, answers to questions like those above are now readily available. It is the purpose of this article to describe the contribution which the hospital can make to the treatment and prevention of poisoning.

The need for constructive action was pointed out several years ago by Bain,[1] who demonstrated that deaths from accidental poisoning were four times higher in the United States than in Great Britain. Children under five years of age, who constitute little more than one-tenth of the total population, account for nearly three-tenths of the poisoning fatalities. Reports from poison control centers indicate that children under five account for about three-fourths of all the nonfatal cases treated.

HISTORY OF CONTROL CENTERS

Within the last five years, primarily as a result of studies by the American Academy of Pediatrics' Committee on Accident Prevention, an organized approach has been developed to deal with poisoning accidents. The keystone of this effort is the "poison control center," located usually in a community hospital.

Through state units of the AAP it has been possible to develop accident prevention committees in nearly all states. The committee in Illinois, under the chairmanship of Dr. Edward Press, developed a pattern for the poison control program which soon aroused nationwide interest. The program began in November 1953. Participating in it were six hospitals, the Chicago

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Board of Health, and the state toxicological laboratory. In less than a year, the 6 hospitals grew to 20 and the program expanded to neighboring areas. A manual for the treatment and recognition of toxic agents was prepared and is now an official publication of the AAP.[2]

Washington, D.C., Boston, and New York City followed Chicago's lead. Participating in New York City are most of the city's hospitals, local county medical societies, a pediatric advisory committee, and the chief medical examiner's office.

At the present time more than 100 centers are in operation in 40 states, Washington, D.C., and Hawaii. The manner of organization varies with the community and its medical and related facilities. The core around which the program operates may be a health department, a hospital, a medical college, a local medical society, or a combination thereof.

THE HOSPITAL'S ROLE

Some hospitals hesitate to establish such centers thinking the procedure is too involved. Most hospitals, however, already have most of the facilities and equipment for this service and need only suggestions regarding coverage, basic texts, etc. To meet the growing number of requests for such advice in setting up poison control programs, the American Academy of Pediatrics' Committee on Accident Prevention has prepared a guide[3] with the following suggested activities:

The Food and Drug Administration has compiled a bibliography of sources of information on the composition of brand name household preparations. This list is available from the research and reference branch, Bureau of Medicine, U. S. Food and Drug Administration, Washington 25, D. C.

A. TREATMENT

1. Development of a 24-hour a day poison information and treatment service to physicians. (Information to parents is limited to first-aid instructions.)

Provision for 24-hour service has posed a problem for some of the centers, but most of them have solved it successfully. Telephone coverage over a 24-hour period can be achieved through the emergency room service of one or more participating hospitals. The services of the intern or resident on call are used and he decides when to telephone his superior or the designated outside consultant. The telephone exchange of the local medical society is another way used to furnish 24-hour information, and one large city health department (New York City) has 24-hour telephone information service available.

Some hospitals have hesitated to introduce this service because of the possibility of litigation which might result through furnishing treatment information. As a protection against liability, the hospital should give medical treatment information only to physicians. Information to parents and other laymen should consist of first aid advice. (Centers can, of course, take out liability insurance, if they so desire.)

2. Development of 24-hour a day emergency treatment facilities.

3. Research on most effective treatment methods.

B. PREVENTION

1. Compilation of reports on the type of poisons encountered and of the response of patients to treatment.

2. Periodic summaries and conferences to develop information for distribution to the general medical staff, to pharmacists, veterinarians, nurses, etc.

To insure proper functioning and to give continuity to the hospital's role in poison control, a member of the attending staff of each participating hospital should be designated a poison control officer (with an alternate or associate officer also named) to coordinate and direct the hospital's efforts. The suggested

—protective bottle cap

Detective Sergeant Lou Belle, Los Angeles, exhibits the safety cap for bottles he has designed to prevent children from accidentally drinking poisonous liquids. The protective cap can easily be removed by an adult but stymies a child between one and five, the ages at which most such accidents occur. Sergeant Belle got the idea for the cap after being called upon for routine investigations of many poisoning accidents.

Reference Books for the Emergency Room

(The bibliography below lists publications which every hospital can obtain at little or no expense. Available in the emergency room, they may be life saving.)

1. *Accidental Poisoning in Childhood.* American Academy of Pediatrics, Evanston, Ill., 1955.
2. *Procedure Book for the Management of Childhood Poisoning.* Boston Poison Information Center, 300 Longwood Avenue, Boston, Mass.
3. *Clinical Memoranda of Economic Poisons.* Technical Development Laboratories, Communicable Disease Center, U.S. Public Health Service, Savannah, Ga. One copy free. (Especially helpful on pesticides.)
4. *Physicians' Desk Reference to Pharmaceutical Specialties and Biological.* Medical Economics, Inc., Rutherford, N.J. One copy free. (Useful for toxic ingredients in medications, also has a small section on poisoning treatment.)
5. *Handbook of Poisons.* Robert H. Dreisbach, M.D., Ph. D. The Lange Medical Publications, Los Altos, Calif., $3.
6. *Pesticide Handbook.* Donald H. Frear, College Science Publishers, State College, Pa., $2.
7. The latest publication which is very comprehensive, though somewhat more expensive than the publications mentioned above, is:
   Clinical Toxicology of Commercial Products. Gleason, Gosselin, and Hodge. The Williams and Wilkins Company, Baltimore, Md., 1957.

duties of such a poison control officer are:

- To be familiar with all the poison control facilities in the community.
- To see that regular operating procedure for 24-hour a day treatment of poisoning is developed. This would include determining initially and by periodic checks the easy availability of the necessary drugs, appliances, equipment, and references.
- To enlist the cooperation of the house and attending staff in treating and reporting cases of poisoning, including special orientation of emergency room personnel.
- To be on call for consultation as needed. (For this duty particularly an alternate is desirable.)
- To arrange periodic hospital conferences and to serve as a liaison between the participating hospital and other participants in the community.

It is to be expected that hospitals which constitute major medical centers will take a more extensive part in professional education and research and will have more complete reference, information, and treatment services.

Obviously, not all hospitals will find it possible or desirable to institute a program providing all of the elements outlined above. Every hospital, however should be prepared to give assistance to the frantic parent or the perplexed physician who seeks help in a poisoning emergency.

Poison control is a new life saving service in which the community hospital plays the key role. The rapid development of these centers attests to the need for a ready source of information on the management of chemical poisoning. The extent to which hospitals can or should organize to provide this service depends upon the size of the community served, its health resources, and the number and type of hospitals. This activity is a further illustration of how today's hospitals function as community health centers. ■

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1. Bain, Katherine. Death due to accidental poisoning in young children. *Journal of Pediatrics.* June 1954.
2. *Accidental Poisoning in Childhood.* (Am. Academy of Ped. manual.) Evanston, Ill., 1955.
3. *Guide to the Organization of a Poison Control Center.* (Am. Academy of Ped. manual.) Evanston, Ill., 1956.

RECOMMENDATIONS OF AMERICAN MEDICAL ASSOCIATION'S COMMITTEE ON TOXICOLOGY

first-aid measures for poisoning

The following recommendations on first-aid measures for poisoning have been adopted by the American Medical Association's Committee on Toxicology. The recommendations are intended for use in educating the public in what to do when poisoning occurs. They may serve as a helpful addition to a hospital's lobby and outpatient department literature or as source material for a mailing to the public. Reprints of this report may be obtained by writing to the Committee on Toxicology, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

PLEASE TEAR OUT ALONG THIS LINE

FIRST-AID MEASURES FOR POISONING

Recommendations of American Medical Association's Committee on Toxicology

The aim of first-aid measures is to help prevent absorption of the poison. SPEED is essential. First-aid measures must be started at once. If possible, one person should begin treatment while another calls a physician. When this is not possible, the nature of the poison will determine whether to call a physician first or begin first-aid measures and then notify a physician. Save the poison container and material itself if any remains. If the poison is not known, save a sample of the vomitus.

MEASURES TO BE TAKEN BEFORE ARRIVAL OF PHYSICIAN

I. SWALLOWED POISONS

Many products used in and around the home, although not labeled "Poison," may be dangerous if taken internally. For example, some medications which are beneficial when used correctly may endanger life if used improperly or in excessive amounts.

In all cases, *except those indicated below*, REMOVE POISON FROM PATIENT'S STOMACH IMMEDIATELY by inducing vomiting. This can not be overemphasized, for it is the essence of the treatment and is often a lifesaving procedure. Prevent chilling by wrapping patient in blankets if necessary. Do not give alcohol in any form.

A. Do Not Induce Vomiting If:

1. Patient is in coma or unconscious.
2. Patient is in convulsions.
3. Patient has swallowed petroleum products (i. e., kerosene, gasoline, lighter fluid).
4. Patient has swallowed a corrosive poison (symptoms: severe pain, burning sensation in mouth and throat, vomiting).

CALL PHYSICIAN IMMEDIATELY

(a) Acid and acid-like corrosives: sodium acid sulfate (toilet bowl cleaners), acetic acid (glacial), sulfuric acid, nitric acid, oxalic acid, hydrofluoric acid (rust removers), iodine, silver nitrate (styptic pencil).

(b) Alkali corrosives: sodium hydroxide—lye (drain cleaners), sodium carbonate (washing soda), ammonia water, sodium hypochlorite (household bleach).

If the patient can swallow after ingesting a *corrosive poison*, the following substances (and amounts) may be given:

For acids: milk, water, or milk of magnesia (1 tablespoon to 1 cup of water).

For alkalis: milk, water, any fruit juice, or vinegar.

For patient 1-5 years old—1 to 2 cups.

For patient 5 years and older—up to 1 quart.

B. Induce Vomiting When Non-corrosive Substances Have Been Swallowed:

1. Give milk or water (for patient 1-5 years old—1 to 2 cups; for patient over 5 years—up to 1 quart).
2. Induce vomiting by placing the blunt end of a spoon or your finger at the back of the patient's throat, or by use of this emetic—2 tablespoons of salt in a glass of warm water.

When retching and vomiting begin, place patient face down with head lower than hips. This prevents vomitus from entering the lungs and causing further damage.

II. INHALED POISONS

1. Carry patient (do not let him walk) to fresh air immediately.
2. Open all doors and windows.
3. Loosen all tight clothing.
4. Apply artificial respiration if breathing has stopped or is irregular.
5. Prevent chilling (wrap patient in blankets).
6. Keep patient as quiet as possible.
7. If patient is convulsing, keep him in bed in a semidark room; avoid jarring or noise.
8. Do not give alcohol in any form.

III. SKIN CONTAMINATION

1. Drench skin with water (shower, hose, faucet).
2. Apply stream of water on skin while removing clothing.
3. Cleanse skin thoroughly with water; rapidity in washing is most important in reducing extent of injury.

IV. EYE CONTAMINATION

1. Hold eyelids open, wash eyes with gentle stream of running water *immediately*. Delay of few seconds greatly increases extent of injury.
2. Continue washing until physician arrives.
3. *Do not use chemicals;* they may increase extent of injury.

V. INJECTED POISONS (scorpion and snake bites):

1. Make patient lie down as soon as possible.
2. Do not give alcohol in any form.
3. Apply tourniquet above injection site (e. g., between arm or leg and heart). The pulse in vessels below the tourniquet should not disappear, nor should the tourniquet produce a throbbing sensation. Tourniquet should be loosened for 1 minute every 15 minutes.
4. Apply ice-pack to the site of the bite.
5. Carry patient to physician or hospital; DO NOT LET HIM WALK.

VI. CHEMICAL BURNS

1. Wash with large quantities of running water (except those caused by phosphorus).
2. Immediately cover with loosely applied clean cloth.
3. Avoid use of ointments, greases, powders, and other drugs in first-aid treatment of burns.
4. Treat shock by keeping patient flat, keeping him warm, and reassuring him until arrival of physician.

MEASURES TO PREVENT POISONING ACCIDENTS

A. Keep all drugs, poisonous substances, and household chemicals out of the reach of children.
B. Do not store nonedible products on shelves used for storing food.
C. Keep all poisonous substances in their original containers; do not transfer to unlabeled containers.
D. When medicines are discarded, destroy them. Do not throw them where they might be reached by children or pets.
E. When giving flavored and/or brightly colored medicine to children, *always* refer to it as medicine—*never* as candy.
F. Do not take or give medicine in the dark.
G. *READ LABELS* before using chemical products.

PLEASE TEAR OUT ALONG THIS LINE

EMERGENCY telephone numbers

HOSPITAL _____ (resuscitator) PHYSICIAN _____ PHARMACIST _____

RESCUE SQUADS _____ FIRE DEPT. _____ POLICE _____

hospitals and poison control:

national clearinghouse for poison control centers

- *what it does*
- *how it works*
- *how it can help hospitals*

by HOWARD M. CANN, M.D.

Because of the ever-increasing list of poison control centers and the growing number of toxic products in consumer circulation, a National Clearinghouse for Poison Control Centers has been organized. The author discusses the services presently offered by the Clearinghouse and its future plans in the field of poison control.

IT IS INTERESTING today to speculate on the changing pattern of disease. The diseases which at the turn of the century were the leading causes of morbidity and mortality have, for the most part, succumbed to the advances of modern science. In their place, however, we find that we are dealing with a new set of diseases. Infectious disease has given way to degenerative disease, malignant disease, and accidents as the leading causes of morbidity and mortality.

These "newer" diseases appear to be keeping pace with the newer developments in science, industry and technology. Paradoxically, the advances of industry and science seem to have brought into existence new health problems. One of these is the problem of accidental poisoning for the introduction of time and labor-saving products into the home has multiplied occurences of accidental poisoning.

Last year 1431 people died from accidental ingestion of poison.[1] Add to this total a similar number of people dying from intentional ingestion of poison. Then consider the ratio of 1 to 100—one death for every hundred poisonings[2,3]—and it becomes apparent that poisoning is an increasingly significant medical problem.

In answer to the need for poison control, a new type of institution—the poison control center—came into being. Since 1953 when the first formal center was set up, such agencies have become an important part of the medical scene.

MASTER CENTERS

The centers are usually associated with a medical school or a large hospital. Often a center is sponsored by a medical society, and public health assistance on either the local or state level has played a part in its creation. Some centers, with varied facilities such as laboratory, library, house staff, and faculty, take the role of "master centers." These "master centers" can give information and treatment on a 24-hour basis. Hospitals with less complete facilities act as subcenters giving 24-hour treatment, but contacting the "master centers" for information if necessary.

Because of the ever-increasing list of poison control centers, and because of the growing number of products placed in consumer circulation by industry, coordination of the activities of the poison control centers seemed necessary.

CLEARINGHOUSE FORMED

Accordingly, on Nov. 12, 1956, at a meeting of the American Public Health Association, a recommendation was made that a National Clearinghouse for Poison Control Centers be set up by the U.S. Department of Health, Education, and Welfare. This meeting was attended by representatives from poison control centers and from such national organizations and government agencies as the American Academy of Pediatrics, the American Pharmaceutical Association, the Food and Drug Administration, the National Research Council, the Children's Bureau, and the Public Health Service. In compliance with the recommendation, the National Clearinghouse for Poison Control Centers was designated as an activity of the Public Health Service in the Accident Prevention Program.

The definition of a clearinghouse, according to Webster, is "any agency for classifying and distributing." The National Clearinghouse certainly is such an agency, but its scope goes even beyond this definition.

It is an important function of the National Clearinghouse to collect information on poisons or potential poisons. The information is collected from a number of sources. Textbooks and journals of pharmacology, medicine, toxicology, and chemistry are consulted. Existing card files on toxic materials from individual poison control centers are utilized.

Recently a form for reporting individual poisonings was developed by the National Clearinghouse in cooperation with the American Public Health Association. This form gives information about the poisoning, such as symptoms and treatment, and provides follow-up information. These forms are

Howard M. Cann, M.D., is director of the National Clearinghouse for Poison Control Centers, Public Health Service.

distributed to most of the poison control centers. Upon completion and return to the Clearinghouse they are coded, tabulated, and analyzed, thus providing a valuable source of information.

Some of the poison control centers use forms which they developed themselves. These additional sources of information—along with bulletins and other technical material put out by the individual centers—are funneled into the Clearinghouse.

COMPOSITION OF PRODUCTS

The National Clearinghouse contacts industry for the information that manufacturers and distributors can contribute to the over-all picture. In this way it is possible to keep track of new products that may be poisonous and changes in the composition of existing products. Government agencies are also a source of a large amount of significant data.

All such information is classified by the Clearinghouse. An indexed card file for use of all poison control centers is being distributed. The cards in this file are indexed by trade name and contain such information as composition, concentration, and lethal dose of each specific agent; plus symptoms and treatment of poisoning by the agent.

A more extensive card file will be kept at the National Clearinghouse. In addition to the above information the Clearinghouse plans to maintain an ingredients file, cross-indexed with the trade-name file, and containing current information on products used only in specific geographic areas. Information on discontinued products will also be a part of the Clearinghouse file.

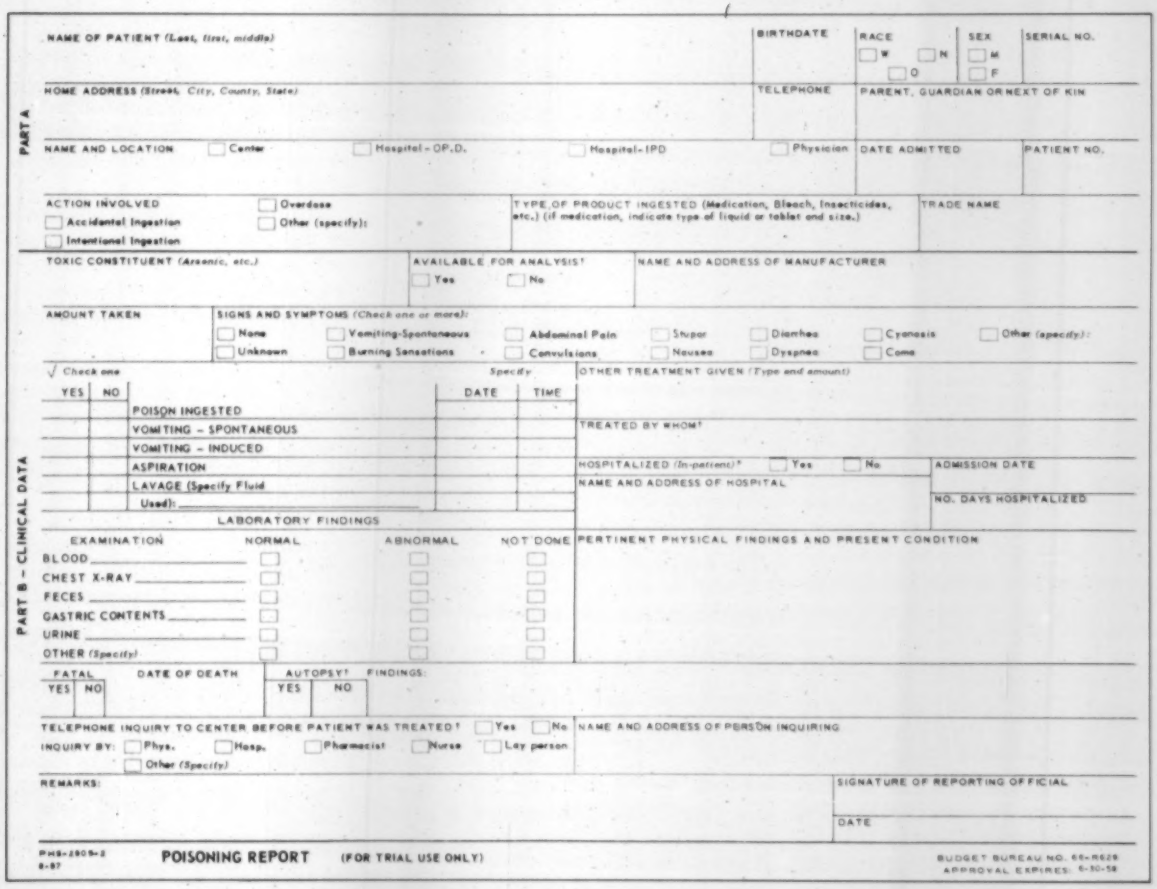
MONTHLY ADDITIONS TO FILE

After the original trade-name card files are distributed to the poison centers, monthly additions will be sent to the centers as new products come on the market, and as existing products come to the attention of the Clearinghouse.

A bulletin is published periodically containing trends and statistics obtained from the poison report form analysis. New work done on poisonous or potentially poisonous materials, reports of new treatments for poisonings found in the literature or used by individual poison control centers, interesting cases of poisoning and abstracts from the literature on poisoning are contained in the periodic bulletins.

The National Clearinghouse can act as a stimulating and encouraging agent for research and studies in the field of poisoning. These may include: epidemiologic research; effects and composition of poisons or potential poisons; development of new treatments for poisoning; and studies of the basic mechanisms and metabolism involved in poisoning. Through such studies we can more fully understand the

FORM FOR REPORTING INDIVIDUAL POISONINGS



PART A

NAME OF PATIENT (Last, first, middle) | BIRTHDATE | RACE ☐ W ☐ N ☐ O | SEX ☐ M ☐ F | SERIAL NO.

HOME ADDRESS (Street, City, County, State) | TELEPHONE | PARENT, GUARDIAN OR NEXT OF KIN

NAME AND LOCATION ☐ Center ☐ Hospital - O.P.D. ☐ Hospital - I.P.D ☐ Physician | DATE ADMITTED | PATIENT NO.

ACTION INVOLVED ☐ Accidental Ingestion ☐ Intentional Ingestion ☐ Overdose ☐ Other (specify): | TYPE OF PRODUCT INGESTED (Medication, Bleach, Insecticides, etc.) (if medication, indicate type of liquid or tablet and size.) | TRADE NAME

TOXIC CONSTITUENT (Arsenic, etc.) | AVAILABLE FOR ANALYSIS? ☐ Yes ☐ No | NAME AND ADDRESS OF MANUFACTURER

AMOUNT TAKEN | SIGNS AND SYMPTOMS (Check one or more): ☐ None ☐ Unknown ☐ Vomiting-Spontaneous ☐ Burning Sensations ☐ Abdominal Pain ☐ Convulsions ☐ Stupor ☐ Nausea ☐ Diarrhea ☐ Dyspnea ☐ Cyanosis ☐ Coma ☐ Other (specify):

PART B – CLINICAL DATA

√ Check one YES	NO		Specify DATE	TIME
		POISON INGESTED		
		VOMITING – SPONTANEOUS		
		VOMITING – INDUCED		
		ASPIRATION		
		LAVAGE (Specify Fluid Used):		

OTHER TREATMENT GIVEN (Type and amount)

TREATED BY WHOM?

HOSPITALIZED (In-patient)? ☐ Yes ☐ No | ADMISSION DATE

NAME AND ADDRESS OF HOSPITAL | NO. DAYS HOSPITALIZED

LABORATORY FINDINGS

EXAMINATION	NORMAL	ABNORMAL	NOT DONE
BLOOD	☐	☐	☐
CHEST X-RAY	☐	☐	☐
FECES	☐	☐	☐
GASTRIC CONTENTS	☐	☐	☐
URINE	☐	☐	☐
OTHER (Specify)	☐	☐	☐

PERTINENT PHYSICAL FINDINGS AND PRESENT CONDITION

FATAL YES ☐ NO ☐ | DATE OF DEATH | AUTOPSY? YES ☐ NO ☐ | FINDINGS:

TELEPHONE INQUIRY TO CENTER BEFORE PATIENT WAS TREATED? ☐ Yes ☐ No | NAME AND ADDRESS OF PERSON INQUIRING

INQUIRY BY: ☐ Phys. ☐ Hosp. ☐ Pharmacist ☐ Nurse ☐ Lay person ☐ Other (Specify)

REMARKS:

SIGNATURE OF REPORTING OFFICIAL

DATE

PHS-2805-2 8-57 **POISONING REPORT** (FOR TRIAL USE ONLY)

BUDGET BUREAU NO. 68-R628 APPROVAL EXPIRES: 6-30-58

problem and fields in which research remains to be done. Studies of data which are tabulated and analyzed at the Clearinghouse, with resultant correlations, will be useful contributions to the field of prevention of poisoning.

NEW CENTERS SET UP

Helping new poison control centers set up operations is another function of the National Clearinghouse. Necessary materials and information in the form of recommended texts, the card file, and bulletins are available to new centers. Poison report forms are not only supplied, but upon completion are coded, analyzed, and tabulated for the new centers. Technical assistance in actually setting up a center is given by the director or the special consultant to the Clearinghouse.

It is fitting that Dr. Edward Press, who has contributed so much to the field of poison control, serves as special consultant to the Clearinghouse. In this capacity he has been actively assisting in the establishment of new poison control centers.

The answer to the problem of accidental poisoning is prevention of poisoning before poisoning occurs. By publishing statistics and trends for physicians and poison control centers to study, the National Clearinghouse will have a role in the field of prevention. Providing educational programs for professional and lay citizens via local poison control centers is also a function of the National Clearinghouse. Carrying the concept of poisoning prevention, which ties in with accident prevention, to the medical schools so that our future doctors may be well versed in this problem is another important responsibility.

The National Clearinghouse receives valuable assistance from the U. S. Public Health Service regional offices. These offices give organizational aid to new poison control centers. Records consultants of the regional offices are available for assistance in establishing or modifying record-keeping and tabulating procedures. These offices are effective in presenting an over-all picture of poison control activities in their specific regions.

CLEARINGHOUSE STAFF

The National Clearinghouse for Poison Control Centers is headed by a director who is a pediatrician. The pediatricians were one of the first groups to take an interest in the field of accidental poisoning. The assistant director is a pharmacist with a Master of Science degree who has a wide knowledge of pharmacology and toxicology. The National Clearinghouse is also staffed by statistical experts, who are available both for Clearinghouse purposes and to assist other groups involved in the study of poison control. In addition record analysts, an educational specialist, and nursing consultants work closely with the National Clearinghouse.

An advisory committee soon to be formed will assist in formation of basic policy for the clearinghouse. The members of this committee will be chosen from various organizations related to poison control. The American Medical Association, the American Academy of Pediatrics, the American Public Health Association, the American Hospital Association, and the American Pharmaceutical Association will represent medical and allied fields on the advisory committee. Industry will be represented by manufacturing pharmaceutical and chemical organizations. Of course, the poison control centers themselves will also be represented.

At present the Clearinghouse is involved in a review of poison control centers. This is a study of the needs, methods of operation, and scope of the poison control centers as they exist today. No study of this sort has been undertaken in the past, and it is anticipated that the results from this study will point out the direction the field of poison control will take in the future.

It is hoped that through cooperation of lay and professional organizations, of the National Clearinghouse and poison control centers, and with the aid of industry and government, one of the "new diseases" in our modern civilization will be controlled. ■

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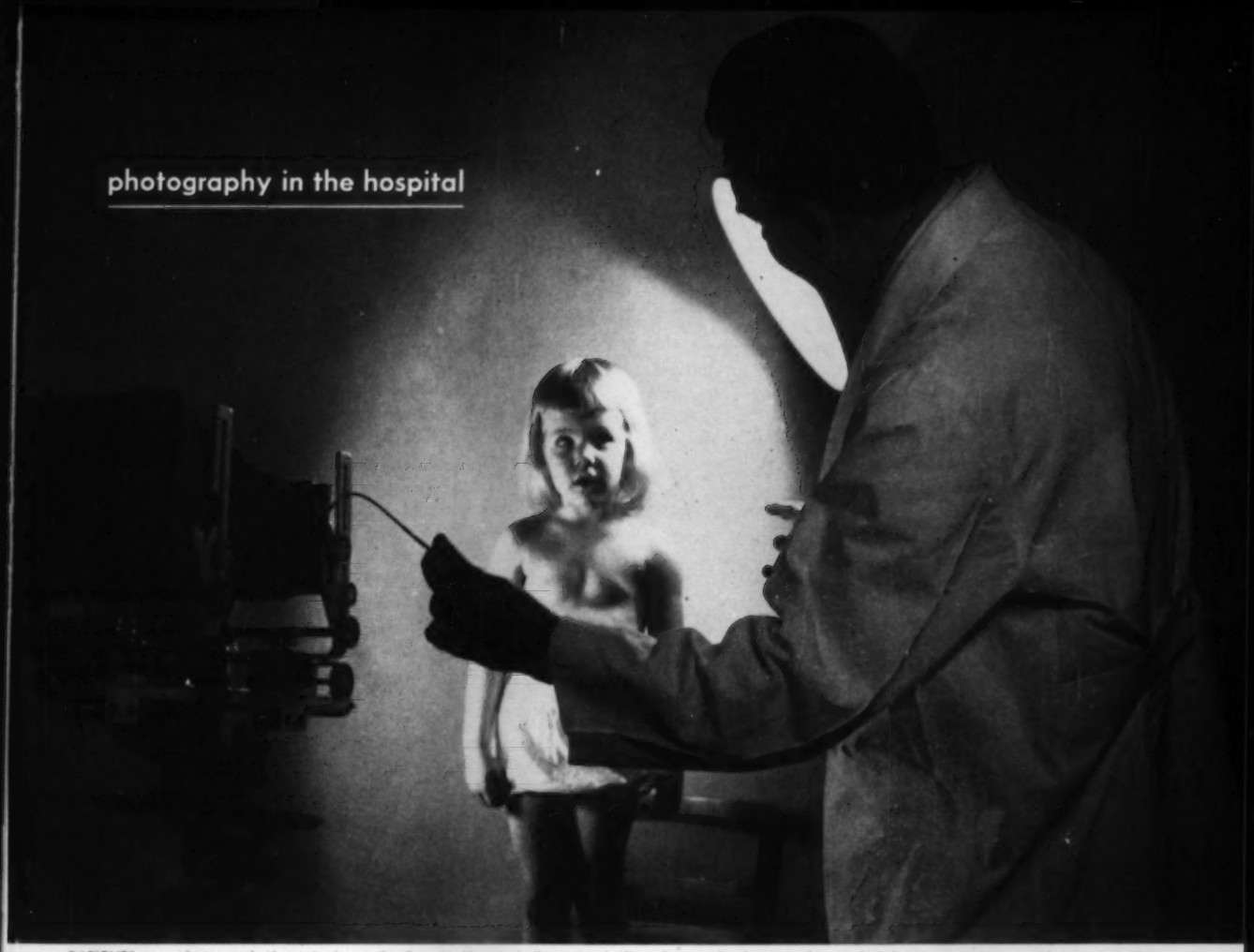
3. Mellins, R. B., Christian, J. R. and Bundeson, H.N. The natural history of poisoning in childhood. *Pediatrics* 17 3:314, March, 1956.

–pharmacists and poison control in Delaware

Pharmacists are helping lead the way in Delaware's poison control efforts. The Delaware Poison Information Service, Delaware Hospital (Wilmington), has its office in the hospital's pharmacy. During the time the pharmacy is open—9 a.m. to 5 p.m. weekdays and 9 a.m. to 4 p.m. holidays and weekends—the pharmacist on duty answers all calls coming to the poison information service.

Physicians are given complete pharmacological information and such medical information as is available. In addition to an extensive library, the office contains a card file on both potentially poisonous products and treatment for poisoning by these products. Lay persons are given commonly accepted first aid information and are asked to go to the nearest hospital or doctor's office.

Calls coming to the poison center at times when the pharmacy is closed are taken by the hospital's emergency ward clerk who calls a specially designated poison control resident. Thus information is available on a 24-hour basis to physicians and laymen of Delaware.
—J. R. CATHCART, *director of pharmacy service, Delaware Poison Information Service, Wilmington, and* ROBERT SIMONS, *director of pharmacy service, Memorial Hospital, Wilmington.*



PATIENTS are photographed routinely at St. Francis Hospital, Evanston, Ill., when such photographs are helpful in providing a progress record.

four views of a visual aid department:

program
layout
equipment
staffing

by MARTIN SAREN and SIDNEY SHAPIRO

As they describe the visual aids program at Long Island Jewish Hospital, the authors discuss the medical and nonmedical areas such a program can serve. They also provide detailed information on space, equipment, and personnel requirements for a visual aids department.

SINCE PRIMITIVE man first scratched a few lines on the walls of his cave, pictures have entertained, instructed, and provided expression for all of us. Improved by modern technology, visual aids have added the values of pictures to programs of today's hospitals.

Visual aids help physicians fight disease with information about treatment, research and education. In various ways, too, visual aids can serve nonclinical functions in hospitals.

The 250-bed Long Island Jewish Hospital, for example, has an extensive and successful visual aid program. The hospital serves a semi-urban community with patients whose economic status ranges from medically indigent to upper middle class. In the hospital's program, emphasis is placed on teaching and research. An annual research budget of $130,000 supports a number of persons engaged in clinical and laboratory research.

The hospital's department of visual aids was so named because its functions include services other than medical photography. Medical photography in most small hospitals is a function of the pathology department. With the expanded program at Long Island Jewish Hospital, however, a separate department has been established with a department head responsible directly to administration. This arrangement enables the department head to portion his time to meet the needs of all other

Martin Saren is acting administrator and Sidney Shapiro is chief of the visual aids department, Long Island Jewish Hospital, New Hyde Park, Long Island, N.Y.

MAJOR EQUIPMENT USED IN DEPARTMENT OF

CAMERAS

1. For general studio and location work—5 by 7 in. view camera, monorail type, with interchangeable backs of 5 by 7 in., 4 by 5 in., 3¼ by 4¼ in. sheet film sizes, and 35 mm. roll film size. Equipped with commercial type lens, 8 in. focal length, mounted in a fully synchronized shutter.

2. For copying of opaque material and radiographs, also specimens—8 by 10 in. view camera with interchangeable backs of 8 by 10 in., 5 by 7 in., 4 by 5 in., and 3¼ by 4¼ in. sheet film sizes. Equipped with commercial type lens, 10 in. focal length mounted in a fully synchronized shutter.

3. For location and public relations work—4 by 5 in. press type camera with commercial type lens, 5½ in. focal length, mounted in fully synchronized shutter, equipped with full flash gun assembly including extensions.

Note: Mounts have been provided so that any of the lenses listed with the above three cameras may be used at will on either of the view cameras, thereby extending the flexibility of each.

4. 35 mm. single lens reflex camera with normal focal length and telephoto lenses, with automatic or preset type diaphragms. Provided with portable electronic flash unit for general illumination and close-up work. Used in situations where larger equipment is not practical nor necessary.

5. 35 mm. single lens reflex camera with normal and long focal length lenses. Mounted on vertical stand for specimen photography in the mortuary. Extension tubes and focusing bellows attachment of the rack and pinion type make possible photography of the largest specimens down through the tiniest specimens requiring some degree of magnification.

CAMERA STANDS

1. Large studio stand on rollers; adjustable for camera positions from 10 feet to floor level.

2. Heavy duty portable, folding tripod, to accommodate large cameras on location.

3. Light-weight, folding, center post tripod; for small cameras.

ILLUMINATION

1. For general studio illumination—1000 watt-seconds electronic flash unit with built-in modeling lights; two lamps supplied by a single power source, triggered by camera shutters; mounted on heavy duty, portable stands with casters. Another independent electronic flash unit, 400 watt-seconds, of the focusing spotlight type, mounted on a boom stand, having its own power source triggered by a photo-cell.

2. For specimen photography in the mortuary—Two reflector photofloods mounted on heavy stands with light polarizing filters attached.

3. A number of reflector photofloods with alligator type clamps and light weight folding stands.

DARKROOM EQUIPMENT

1. Enlarger, condenser type, to accommodate 35 mm. to 4 by 5 in. size negative material; two lenses with condenser heads to match; reducing attachment. Electronic timer attached.

2. Enlarger, diffusion type, to accommodate up to 5 by 7 in. size negative material; reducing attachment. Electronic timer attached.

3. Easels to accommodate print sizes up to 16 by 20 in.

4. Professional type contact printer to accommodate up to 8 by 10 in. size negative material.

departments using visual aid services. He also is able to choose the equipment and supplies, which, from his experience he knows to be best for carrying on his work.

THREE SERVICES OFFERED

The department of visual aids at the hospital offers three general areas of service—medical illustration, nonmedical illustration, and consultative services. The following outline describes these services.

A. Medical Illustration

1. Clinical photography. This includes photography of ambulatory and bed patients either in the studio or at the patient's bedside. It provides a record of lesions, malformations, pre-and postoperative appearances, the progress of disease and treatment. Photographs range from full figures to close-ups of limited skin areas and they are done in both black and white and color. Motion picture photography is also available and is used in clinical work.

2. Surgical photography. The recording of surgical fields in color during progressive stages of operations in still and motion pictures is of particular importance in a teaching hospital. These pictures provide a record of a host of activities and are ideal tools for teaching, research and training. A well made film of a surgical procedure is often a better teaching method than direct observation since it may be edited to omit nonessential or familiar detail. A film also provides close up views not always visible to observers, and it may be re-shown as many times as the teaching staff deem necessary. Unusual operative conditions and special techniques do not occur frequently enough so that all residents and interns may see them during their term of training. Pictorial records of these rare events can be shown at conferences and discussed in lieu of "on the scene" observations.

3. Specimen photography. Color photographs of fresh anatomical specimens preserve on film the specimens' fresh appearance and natural color. The process reduces the need for preserving actual specimens in jars. Such a technique can save considerable space, since thousands of pictures can be stored in a small cabinet, indexed and classified for ready reference. These pictures are also useful for publications. The values of human specimen photography are applicable to research with animals or tissue and bacterial cultures as well.

4. Photomicrography. A diagnostic study is more reliable when the clinical findings are supported by microscopic studies. Pictures of such studies provide a permanent record for future references, teaching and research.

5. Copying. A good part of the

VISUAL AIDS, LONG ISLAND JEWISH HOSPITAL

5. Stainless steel sinks for print processing and negative processing, each with its own automatic temperature control device on the water supply.
6. Stainless steel print washer.
7. Stainless steel trays, 16 by 20 in., 11 by 14 in., 8 by 10 in., 5 by 7 in.
8. Stainless steel negative processing tanks with light-tight lids.
9. Stainless steel negative washing tank.
10. Stainless steel negative developing hangers for all the film sizes mentioned.
11. Electrically heated, forced draught, negative drying cabinet.

PHOTOMICROGRAPHIC EQUIPMENT

1. Research type microscope equipped with combination viewing and photo tube, revolving mechanical stage, quadruple nosepiece, focusing condenser, objectives 52 mm., 12 mm., 4.3 mm., 1.8 mm., oculars. All optical elements centerable.
2. Low power stage with 28 mm., 50 mm., 90 mm., lenses and matching condensers.
3. Above mounted on a single vertical stand with 4 by 5 in. reflex type camera head and long adjustable bellows; interchangeable 35 mm. camera back. Microscope and low power stage utilize same camera heads and light source; authors recommend separate units if budgets will permit.
4. Light source—100 watt zircon arc lamp in focusing condenser housing.
5. Complete set of filters:
a) For black and white photography;
b) For color correction;
c) For neutral density.
6. Sensitive galvanometer with masked photocell attached, for direct reading of level of illumination on ground-glass.

ART EQUIPMENT

1. Large drawing board with attached parellel ruler.
2. Lettering equipment:
a) Fixed size templet type;
b) Variable size templet type.
3. Triangles, french curves, engineers and architects scales.
4. Lettering pens, brushes, etc.
5. Complete set mechanical drawing instruments.
6. Mat knives, frisket knives, circle cutters.

MISCELLANEOUS EQUIPMENT

1. Print dryer, electrical, rotary drum type.
2. Dry mounting press and tacking iron.
3. X-ray illuminators.
4. Color transparency viewer.
5. Roller backgrounds hung from studio ceiling, black, white, red, blue.
6. Photocopy equipment, up to legal size.
7. Stainless steel wheeled cart for transporting equipment.
8. Sheet film holders in all the film sizes mentioned.
9. Exposure meters, incident and reflected light types.
10. Fully automatic camera, 35 mm. size, for use by nursery personnel in new-born photography. Electronic flash unit built in. Shutter, film advance and illumination actuated by a single hand button switch.
11. Office equipment—typewriter, desks, file cabinets, telephone, etc.

work of the visual aid department consists of photographic copying of other visual material such as x-rays, drawings, charts, graphs and figures from books and periodicals. This material is used to produce lantern slides for teaching and other lecture purposes, and pictures for publications.

6. Art work. The production of charts, graphs, and drawings of professional quality is a function of obvious value. Good graphic arrangement and rendition enhance any lecture, publication, or other presentation.

7. Design of scientific exhibits. A well designed exhibit telling the story of a research project, interesting or unusual clinical findings, or even a description of a new service, technique, or apparatus, can lend prestige to the exhibit's authors and the institution from which it emanates.

B. Nonmedical Illustration

1. Public relations. Black-and-white color photographs in both still and motion pictures improve the public relations program at Long Island Jewish Hospital. Pictures are taken of professional and special events, distinguished visitors, new construction, group meetings, and volunteers and resident staff. These photos are used for newspapers, magazines, annual reports, fund raising brochures, educational meetings and many other purposes.

2. Photocopying. This service entails the use of a photocopying machine. Its operation is entrusted to clerical personnel of the department. It is used extensively for hospital records, insurance reports, certificates and letters.

3. Newborn photography. This service involves the photographing of all newborn in the admitting nursery. Nurses photograph the infants using fully automatic equipment. The technical aspects of the service are handled by the visual aids department. Sales and clerical functions are carried on by volunteers. Formerly, this work was done by a commercial photographic service. With the formation of the department of visual aids, at very little extra cost, the technical photographic functions were taken over by this department. The profit formerly made by the commercial photographer is now used to offset the costs of operating the department.

4. Portraits. For identification, professional or personal use, the department takes portraits of hospital connected persons.

C. Consultative services

The chief of visual aids can give important advice regarding proper presentation of graphic material for teaching, publications, and research. He may see graphic possibilities in many projects which are not obvious to the workers engaged in them. He can offer valuable assistance in arrangement of

conference rooms, auditoriums, bulletin boards and hospital exhibits to enhance the effectiveness of visual presentations. Perhaps the most valuable consultative function is advice to the professional staff in proper preparation of material for publication.

STAFFING DEPARTMENT

As in most departments personnel requirements for a visual aid department are related to the size and type of hospital and scope of teaching and research programs in progress. The interest of staff members in visual aids is also a material factor, although their interest will grow if the facilities and properly trained personnel are provided.

A survey report of 50 hospitals having medical photography programs provides some guidance in the matter of personnel requirements. The average requirement suggested is one photographer for every 225 beds, subject to the factors previously noted. The departments surveyed, however, did not all provide similar service. Furthermore, the range of possible and desirable services is expanding rapidly as new techniques are developed and existing methods refined.

The visual aids department at Long Island Jewish Hospital was staffed initially by a chief and a secretary-assistant. The chief has full administrative responsibility and carries out and supervises all the technical phases of the work. The secretary-assistant is responsible for the secretarial, clerical, and receptionist work as well as various simple technical tasks such as lantern slide binding, print drying, and photocopying.

SELECTING DEPARTMENT HEAD

A department head should be selected who (1) has an adequate background in all phases of photography including photomicrography and motion pictures; (2) is familiar with operating room procedures (sterile technique) and the handling of clinical patients; (3) has a working knowledge of human anatomy; and (4) possesses a thorough knowledge of the processes of graphic reproduction. He should be skillful in making charts and graphs, and in the use of mechanical drawing and lettering instruments. Some administrative experience with emphasis on the supervision of subordinate employees is desirable.

PHOTOMICROGRAPHIC studies provide a permanent record for future references, teaching and research. Inset shows a fungus culture, the type of work possible with the apparatus shown in the large photo.

Adequately trained individuals may be difficult to find. College trained men and women are not usually attracted to the hospital field because of the traditional small remuneration. Schools offering courses are few, and the duration of training is generally short and superficial in nature.

Perhaps the best source of personnel is departments of medical photography in large, long established institutions. Here individuals are employed who have schooling in fundamental subjects and are trained on-the-job by competent chiefs. The establishment of an efficient visual aids department in smaller hospitals will provide avenues of advancement for these competent, well-trained individuals, and opportunities for the training of additional people.

The employment of enthusiastic amateurs should usually be avoided. Frequently found in hospitals among laboratory and x-ray technicians, their interest in photography is sincere but they do not have the background necessary to meet the varied demands of a complete visual aids service.

The secretary-assistant should be a competent typist and have an elementary knowledge of bookkeeping. She can be trained by the chief in the few required technical duties in a short time. Preferably, this job should be filled by a woman since she can be present when it is necessary for a female patient to disrobe for photographic purposes.

EXPENSIVE EQUIPMENT ECONOMICAL

Equipment selection is also largely related to the specific needs of the hospital and working preferences of personnel. The best available equipment should be provided. This usually means purchasing expensive equipment, but this practice is more economical in the long run. Such equipment will give the most accurate and dependable service with a minimum of repair over long periods of time.

If budgets permit, there should be separate units of equipment for separate photographic functions. This makes for a minimum of rearrangement and consequent economy of time. If possible, portable units should be in constant readiness for transport to surgery or patients' rooms. Compromises are possible in this regard, of course, and much depends upon the ingenuity of the photographer if such compromises must be made.

We have found certain categories of equipment to be essential. The use of electronic flash equip-

ment, for example, has practically replaced old fashioned floods and flash bulbs for still photography. This is also a fine example of the consideration of long-range economy of time, and dependability of operation over initial high cost.

In the processing rooms, the highest quality stainless steel equipment and temperature-control apparatus will give a lifetime of trouble-free service. The same principle should be applied to all other technical equipment; cameras, camera stands, light stands, enlargers, film holders and hangers, microscopes, etc. (See list of equipment in visual aids department of Long Island Jewish Hospital, pp. 46 and 47.)

LOCAL SPACE LIMITATIONS

Since space is at a premium in most hospitals, the requirements for a visual aids department presented here may be further reduced to meet local conditions.

The department should consist of a photographic studio, office, processing room, and where possible additional small rooms for specialized functions.

1. Studio—18 by 30 feet with a 10 to 16 foot ceiling, where all gross photographic work except bedside, outdoor, or operating room photography is carried out.

2. Processing rooms—Film processing room, 8 by 12 feet; and a print processing room, 8 by 15 feet both with separate entrances through a light-tight vestibule or maze if space permits.

3. Office—sufficiently large to accommodate desks for secretary and chief and filing cabinets.

4. Specialized rooms or areas for photomicrography, film editing, print finishing, and art functions. Each room should be large enough to suit the individuals and equipment involved. Provision should be made for the photography of gross pathologic specimens. This may be in a separate room or by means of a special set-up within the mortuary as is done at Long Island Jewish Hospital. All rooms must completely exclude outside light and must have adequate ventilation.

Space requirements are directly proportional to the volume and variety of the work performed. A special hospital admitting large numbers of orthopedic or plastic surgery patients will probably require more photography, and consequently more space than a general hospital with the same number of beds. Other factors, previously noted, that affect the scope and personnel needs of the department apply to space requirements as well. This discussion of space requirements is intended as a guide only. The space available at Long Island Jewish Hospital falls short of the ideal discussed; yet the hospital's varied program is presently being carried out by means of compromise in the space and layout as shown below.

Preferably a visual aids department should be in the vicinity of other laboratory services, and near enough to the surgical suite and mortuary so that both can be reached quickly by the photographer. It should also be easily accessible to patients, both ambulatory and in wheel chairs or on stretchers. Areas with low ceilings should be avoided.

OPERATES AT DEFICIT

The department of visual aids at Long Island Jewish Hospital operates at a deficit. The rationale of deficit spending may be applied with equal justification to this department as to any service. The deficit has been nominal, however, since costs are spread among those hospital departments requisitioning visual aid services. This work is billed in accord with a fixed rate schedule. Additionally, direct cash income producing activities, including private services for staff and nonstaff physicians and dentists, newborn photography and photocopying, help reduce the deficit. ■

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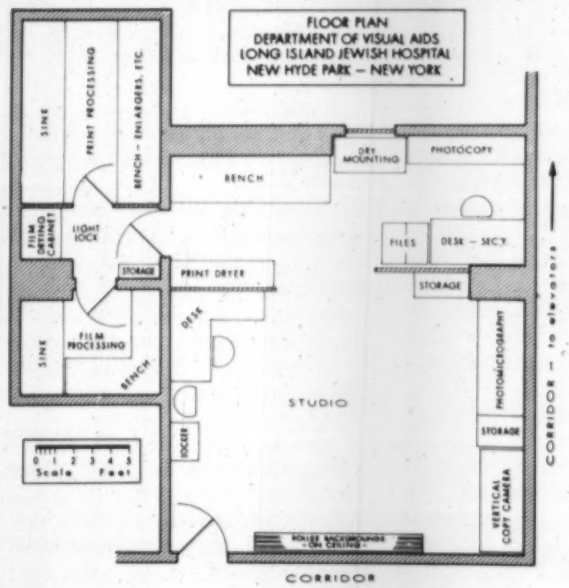
Gibson, H. L. Planning the medical photographic department. *Medical Radiography and Photography*. Vol. 24, No. 3, 1948.

SPACE AND equipment utilized by the visual aids department at the Long Island Jewish Hospital are represented in this floor plan.



THIS photograph illustrates the use of a shielded syringe to protect the operator from radiation during injection of radioactive solutions.

what the community expects of the hospital

by NATHAN STARK

Each administrator of a general hospital, the author states, has a responsibility to establish that hospital as the focal point of community health service. The author also discusses areas of care that general hospitals should add or expand to achieve this goal, including facilities for communicable and chronic disease patients, public education programs, and medical social service.

THE HOSPITAL administrator has attained professional status and along with this prestige, not only in the community but also with his board of directors. With this prestige comes increased responsibility for each administrator to look beyond routine matters of running the local institution and encompass in his thinking general health problems of the community and how the hospital relates to them. The good accomplished by hospitals is not a subject of dispute, nevertheless, the precise place that a hospital should occupy in the community, the proper responsibility for its existence and administration, remains subject to provocative question.

The preference of hospitals for certain types of patients and hospitals' disposition to avoid others is another area in need of clarification. Most of our general hospitals exclude certain cases. Among the grounds for such exclusion are a limited clinical program, fear of contagion, moral prejudice, convenience, expense, race prejudice, and endowment restrictions.

It has not been many years since "the sick" meant the acutely ill, and the hospital's position was stated in this term. A hospital which served the acutely ill primarily and limited its interests to activities within its confines was doing the job expected of it. If a hospital is doing the same job today, however, it is far behind the times. In my opinion, it is failing "the sick" and is not assuming the place that our present community structure demands of a general hospital.

Nathan Stark is vice president, Rival Manufacturing Company, Kansas City, Mo. Mr. Stark is also a member of the Kansas City Area Hospital Association's board of directors; chairman of that association's planning committee; and a member of the Menorah Medical Center's board of directors, also in Kansas City.

INFECTIOUS DISEASES

"In certain hospitals it has been the custom to set apart wards for what are called infectious diseases, but in reality there ought to be no disease so considered. With proper sanitary precautions, diseases reputed to be the most infectious may be treated in wards among other sick without any danger. Without proper sanitary arrangements a number of healthy people may be congregated together so as to become subject to the worst horrors of infection."

This quote is from Florence Nightingale's *Notes on Hospitals*, written in 1863. It has taken us approximately 80 years to catch up and some hospitals still lag behind.

The general hospital in which clinical specialties are combined and proper coordination of effort can be secured is preferable to a loose aggregation of independent institutions which favor isolationism. There are, for example, distinct advantages in a contagious unit of moderate size forming part of a general hospital plant. These advantages are in the utilization of the existing laboratory resources and other hospital facilities and in availability of clinical consultative services. Contagious cases are often avoided by general hospitals partly because so few hospitals are organized and equipped for their prompt detection and proper segregation and partly due to public ignorance.

Hospitals should consider conducting educational programs designed to show the advantages of caring for communicable disease in the general hospital and to gain public acceptance of such procedure. If such programs achieved this objective, special contagious disease hospitals now operated by counties, cities and villages either could be discontinued or their functions could be expanded to include the care of other types of illness.

If communicable diseases are to be cared for in general hospitals it is to be expected that per diem nursing expenses will be increased in proportion to the extent to which isolation techniques and special nursing personnel must be employed. The increased cost of nursing service, however, would be far less in the aggregate than the maintenance of special institutions.

CHRONICALLY ILL PATIENTS

Hospitalization of the chronic sick also presents particularly difficult problems for community hospitals. The chronic patient must be hospitalized not for a few days

or weeks, as is the case in acute diseases, but for months or years, raising the cost of individual service to staggering figures. Chronic disease patients however are not all of one class. The general hospital might well serve those chronically ill patients who require medical care and in whom improvement may be expected. Some special institutions will, of course, be needed to provide care for long-term patients for whom there is little hope of rehabilitation. Even in these instances, however, it would be desirable to have an affiliation between the special institution and a general hospital.

General hospital staff and personnel have adjusted to a tempo suited to acute patients and rarely modify procedures and attitudes to accommodate the long-term patient. It might be wise for general hospitals to examine their policies and practices to see how well their programs fit community needs for hospital service to the chronically ill. The following questions can be used for such an evaluation:

- Is there a category of chronically ill patients who cannot get service because no local institution is provided for them?
- Must some chronically ill patients go outside the community for service which could be given by a local hospital?
- Is continuity of chronic care jeopardized by lack of cooperation among institutions?
- Is quality of care being affected by isolation of a chronic disease facility and disinterest on the part of a general hospital?

If such situations exist, how can they best be corrected? By addition of beds, space, equipment, and personnel in one or another institution? By personnel education within institutions? By closer association of hospitals with each other and with other institutions and health services, to permit better use of facilities and personnel and easy flow of patients from one institution to another?

Perhaps the most difficult obstacle to provision for adequate hospital care of chronic diseases is the almost prohibitive cost involved. It can be shown, however, that the per diem care of the long-term patient is not as great as that of the acutely ill patient.

These individuals can be cared for in a separate unit or department of the hospital. The cost will not be materially greater than that now encountered in special institutions. Many of our chronic disease hospitals are now supported by taxation. The community and other governmental agencies can continue to provide for those patients who cannot pay their own way even though they receive care in the general hospital.

ADMITTANCE OF ALCOHOLICS

Of all chronic diseases alcoholism is perhaps the least acceptable. Many general hospitals will not admit such patients. General hospitals, however, are being increasingly asked to recognize the alcoholic as a sick person. Last September at the annual convention, the American Hospital Association's Board of Trustees stated that:

"The alcoholic should not be denied the advantage of a thorough study of the cause or causes of his condition and should not be denied the advantage of the best possible management of his case."

The AHA statement on admission of alcoholic patients to the general hospital also urges "general hospitals to develop a program for the care of alcoholics and, hav-

—Cupid first class

The Asian flu epidemic, believe it or not, is having a pleasant side effect. In communities where hospitals have greatly reduced the number of visitors, there has been a revival of the almost lost art of letter writing between husbands and wives.

Take Ellis Hospital in Schenectady, for example. A notice in the foyer reads, "We know that you will understand that the visiting reservations are devised to protect your, and our, prime concern—your patient. We hope you will use these envelopes and paper to send along a note for delivery to your patient. You can help us by placing the room number of your patient on the envelope."

Said one doctor with romance in his soul. "It's really heartwarming. Men and women coming to visit their wives or husbands and finding their way barred by the no-visitor rule, are writing love letters to their mates, in some cases no doubt for the first time since they were courting." The other day at Ellis one man spent four hours in the lobby, exchanging letters with his wife. To handle the flood of "intercom mail," more Pink Ladies are being used as messengers.

Even the most romantic among us will no doubt admit that the notes passed between husbands and wives may not be devoted entirely to terms of endearment. If we were to peek over the shoulder of the writers we might find such comments as, "The milkman came to the house today and he said we owe for the past six weeks. What shall I do?"

Or a note in the other direction, "I hope you are getting Jimmy to bed by 9:30, and please don't let those dishes pile up, or it will be an awful mess when I get home."

But even such down-to-earth considerations do not dispel the romance when the note begins, "My Dearest . . ." and ends, ". . . with all my love . . . " thoughts that may not have been expressed in writing by visitor and patient for many a year.

This material, written by Ralph M. Turner of the editorial staff of the Schenectady (N.Y.) Gazette, appeared originally as an editorial in that newspaper. ■

ing done so to base the decision as to admission or nonadmission of the patient with a diagnosis of alcoholism upon the condition and needs of the individual patient.

"This progressive step would keep pace with increased recognition of 1) the general hospital as the community health center and 2) alcoholism as a medical problem requiring broad-scale attack if it is to be solved."

HOSPITALS AND MENTAL PATIENTS

In the matter of mental illness the general hospital should not be expected to provide for all types of patients, but with proper discretion, certain psychopathic cases can be cared for. The general hospital should make available diagnostic and therapeutic services for those cases where the term of illness is of short duration and prognosis favorable. The advantages of avoiding legal formalities, of obtaining consulting services, and the high rate of successful treatment and discharge are worthy of emphasis. In the course of time it is expected that general hospitals will accept more mental cases. Opportunities should also be created for the development of closer relations between the professional personnel of psychiatric hospitals and general hospitals.

CONVALESCENCE AND REHABILITATION

In the interval between discharge from the hospital after an acute illness and the day a patient can return to work, there is usually considerable risk of damage to the patient. Some hospitals have already established convalescent facilities to which the patient may be assigned on doctor's orders, thus providing him a more congenial atmosphere at less cost and permitting more rapid turnover in critical sections.

The Commission on Chronic Illness reports that in too many general hospitals, disregard of rehabilitation possibilities is the rule. An administrator can help remedy this situation by arranging an educational program with the medical staff.

While it is not practical to expect every hospital to have a rehabilitation department it is not impractical to ask that every hospital and every physician study procedures continually to be sure that they are in keeping with the latest advances in therapy and treatment.

In communities where there are community centers and voluntary agencies dealing with rehabilitation, hospitals should correlate their services with these agencies to enable the disabled individual to achieve the maximum restoration to normal health and function. In those communities where such centers do not exist, hospitals should assist in their establishment.

MEDICAL SOCIAL SERVICE

The "First Annual Report of Social Work Permitted at the Massachusetts General Hospital", October 1905 to October 1906 begins:

"In the Out Patient Department of the Massachusetts General Hospital there occurs many times each year a scene not unlike that described in *Alice in Wonderland.*

" 'Have some wine', the March Hare said in an encouraging tone.

" 'I don't see any wine', said Alice.

" 'There isn't any', said the March Hare.

"Without any sense of humor and pathos of the situation we say (in substance) to many patients; 'Take a vacation', or 'Get a job', 'Get a set of teeth' or 'Get a truss'. There is none in sight and no means of getting any. What do we do then? We pass cheerfully on to the next patient."

In the years that have passed since the report was written, the medical social workers at Massachusetts General Hospital have tried to bridge the gap. "To order for one patient a diet which he cannot possibly consume; for the next a vacation which he is too poor to take; to forbid the third to worry when the necessary cause remains unchanged," gives neither satisfaction nor help to any man.

Medical social service is now an integral part of many hospital organizations. Small hospitals as well as large need social service. The basis for hospital social service is its relation to the medical care of the patient. All hospitals, including those in rural areas, need to make these services available to their patients.

It may be possible for a small hospital which is unable to support social service personnel on a full time basis to arrange with one or more hospitals in the area to retain a social worker jointly. It is also desirable that hospitals coordinate their social service with that of other welfare agencies and religious and civic organizations.

THE TEACHING HABIT

It has been said that hospitals really have only two major objectives, (1) care of the sick and (2) education and training of all who come in contact with them. In return for public support, a hospital can, in my opinion, make no greater contribution to its community than a higher level of hospital, medical and nursing practice.

The groundwork for medical practice is laid in the medical school. According to many physicians, however, the most potent force for the education is found in hospitals. Teaching is not a function of the university hospital alone. Hospital staffs everywhere should cultivate the teaching habit. To insure progress a hospital which is thoroughly equipped with laboratories, examining and treatment rooms, and outpatient departments should encourage physicians not identified with the staff to use the laboratory facilities of the hospital, to consult its library, to visit its wards and attend its clinical conferences. While comparatively few hospitals can undertake educational activities in all fields of medicine, nursing, dentistry, etc., every hospital has an opportunity and an obligation to teach.

The teaching function of general hospitals should also be extended to programs of public education. Such programs could disseminate information on new developments in medical science and the part that the hospital plays in them, as well as authoratative advice on the prevention of disease. This kind of activity is important not only in maintaining public health but also in maintaining good public relations.

OUTPATIENT ACTIVITIES

A hospital can perform a service for the community resulting in more careful utilization of beds by

(Continued on page 108)

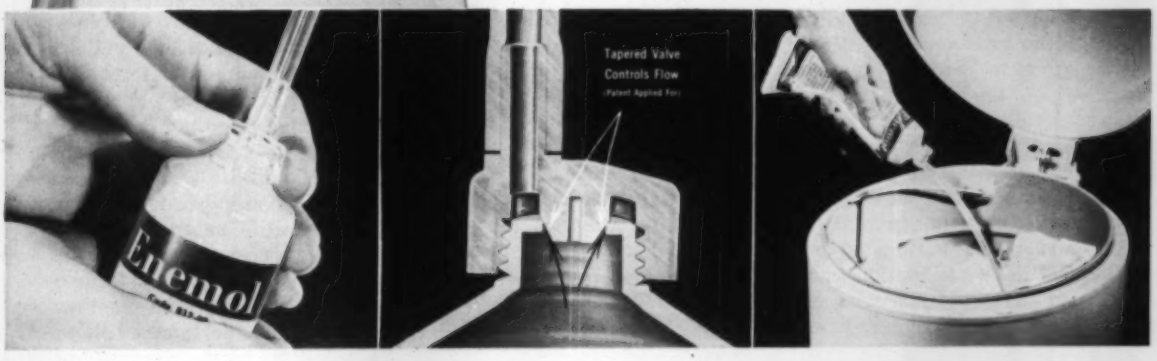
"Enemol makes giving enemas an easier chore"

It used to be that preparing and giving those routine enemas topped my list of "Most Unpleasant Nursing Chores." But, with Enemol – it's so much easier and faster that I don't mind it nearly as much.

The thing I like best about **Enemol*** is that there's no equipment to assemble or solutions to mix. Better yet, there's no messy equipment to clean up afterwards because you just throw the used container away. That means as much as 20 minutes saved – to spend doing something else.

Enemol ***is the only disposable enema*** I know of, with a shut-off valve you can easily open and close with a simple twist. You can even clear air from the tube before inserting. The tube, with its soft round top, is just stiff and long enough (6 inches) to insert easily without hurting the patient.

Having an enema is never pleasant, but Enemol makes it a lot less uncomfortable for the patient to take. That's because there are only 4½ ounces of fluid instead of the usual quart. And for routine enemas, this time-proven phosphate solution really does a better job than soap suds.



Enemol disposable Enema Unit

- *Saves nursing time*
- *Reduces expense*
- *Increases patient comfort*

*TM

Packed in easy-to-handle cases of 24; 4½ oz. units.

60th *fine pharmaceuticals for 60 years*

CUTTER LABORATORIES

BERKELEY, CALIFORNIA

ASSOCIATION SECTION

The following actions were taken by the House of Delegates of the American Hospital Association at its meetings in Atlantic City, N. J., Sept. 29-Oct. 2. Further actions of the House will be reported in subsequent issues of this Journal.

GUIDING PRINCIPLES IN DEVELOPING LEGISLATION TO EXTEND THE HOSPITAL SURVEY AND CONSTRUCTION ACT, AND ADD RENOVATION AND MODERNIZATION GRANTS AND PROVISIONS FOR LOW INTEREST LOANS

Approved by the Board of Trustees Nov. 30, 1956.

Approved by the House of Delegates Oct. 2, 1957.

Part I—Grants for Renovation and Modernization

Introductory Statement

The grants for hospital construction authorized by Title VI of the Public Health Service Act have over the past 10 years resulted, through the assistance and stimulation given to the states and localities, in the construction of many greatly needed hospitals throughout the nation. The hospital construction aided under this title has for the most part been in communities suffering from a total lack or an acute shortage of hospital facilities, a distribution which has been in accordance with the intention that federal funds should be used to supplement the existing facilities in the several states in order that ultimately old and new facilities together should be adequate to meet the needs of the people. In the meantime, however, increasing obsolescence of many existing hospitals has rendered more and more inadequate, in important part, the base upon which the program of new construction was projected. Progress toward the ultimate objective of this title now requires, equally with the continued construction of new facilities, the renovation and modernization of many existing structures, and requires that such renovation and modernization be carried on without reference to the priorities of need for new construction. Accordingly, to carry out further the purposes of the Hospital Survey and Construction Act, it has now become necessary to authorize an additional program of grants, designed to assist the states in restoring and improving the efficiency of their existing hospitals in order that they may better discharge their functions and more effectively utilize their personnel.

Legislation developed for this part should include the following principles:

1. The proposed legislation should establish a separate category under the Hospital Survey and Construction program for renovation and modernization with its own schedule of priorities.

2. The program for renovation and modernization should be applicable to public and nonprofit hospitals, including chronic disease hospitals and, at the option of the state, to diagnostic or treatment centers, rehabilitation facilities and nursing homes.

3. This bill should further amend the Hospital Survey and Construction Act and should coordinate the program for renovation and modernization, at both federal and state levels, with the program for new construction.

4. The bill should provide grants to the states to enable them to survey and report to the surgeon general on the needs for renovation and modernization of all facilities provided for under the Hospital Survey and Construction Act.

5. The federal legislation should provide for an allocation of funds among the states on the same formula, and with the same matching requirements as that under the program for construction grants.

6. The surgeon general with the approval of the Federal Hospital Council and the secretary of the Department of Health, Education, and Welfare should revise and supplement present regulations to provide with respect to renovation and modernization projects general standards of construction and equipment and priorities, and to extend to such projects the other general standards contained in the construction program, other than bed ratios.

7. The states should submit for approval to the surgeon general, on the basis of state survey and as revisions or supplements to their plans for hospital construction, plans for programs of renovation and modernization of public and nonprofit hospitals and other eligible facilities. The states should periodically review their programs for renovation and modernization and submit necessary revisions to the surgeon general.

8. The program for renovation and modernization should be carried out without reference to the priorities of need under the construction program.

9. The procedures for applications, approvals and payment for renovation and modernization projects should be the same as those in the construction program. Application of state standards covering operation and maintenance should be the same as those provided for in the construction program.

10. The program under this part should be limited to the renovation and modernization of existing structures.

11. The legislation for the program of renovation and modernization should carry an annual authorization of $75 million.

Part II—Loans for Construction or Modernization and Renovation of Hospitals and Other Facilities

Introductory Statement

The grants for construction of

(Continued on page 104)

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professional practice

emotional support and aid in financial planning: greatest needs in

caring for the terminally ill

by ELLEN SAUNDERS

The author discusses special casework services provided for patients with incurable lung cancer at the Long Beach Veterans Administration Hospital. She points out that casework must be integrated with the efforts of other hospital personnel to give patients with incurable diseases and their families the strength to function in the face of terminal illness.

INCURABLE DISEASES create special administrative problems within hospitals. Newly diagnosed cases of incurable lung cancer, for example, should be evaluated to determine whether or not case work services are required.

During a six-month period in 1954, a study of the social and economic problems of 24 men who had been given a diagnosis of incurable cancer of the lung was undertaken by the medical social worker assigned to the service at the Long Beach Veterans Administration Hospital. The results showed that 22 out of 24 patients and/or their families needed and used casework services.

The services these patients need occur primarily in two areas—financial planning and emotional support. The full significance of the need for help in both these areas becomes apparent when the following factors are evaluated:

1. What a diagnosis of incurable lung cancer means in terms of a patient's employment status and life expectancy.
2. The low income status of many of these patients.
3. The emotional and mental blocking caused by fear, uncertainty and illness which makes it impossible for some patients to utilize the resources which are within their grasp without help.

NOT ABLE TO WORK AGAIN

A slight cough and increasing shortness of breath may be a patient's only symptoms when cancer of the lung has advanced to the inoperable stage. It is significant, therefore, that none of the 15 men studied who had been employed before coming to the hospital were ever again able to work: 9 were prevented because of the severity of their symptoms; 6 were told by physicians that they might return to light employment but none of them were fitted by education or experience to do anything but hard labor or semiskilled work.

An analysis of the incomes of 22 of these patients disclosed that 98 per cent of them derived all or part of it from sources (government pensions and compensation, disability insurance benefits, social security, etc.) which would either cease entirely or dwindle appreciably with the death of the patient. Therefore, although current income may be adequate for some patients, recognition of the total financial picture, including the knowledge that the income might not continue at its present level, could be a source of great anxiety in many instances to both patients and their families.

Thus financial planning with the patient and/or his family involves immediate exploration of the financial problem and interpretation of such available benefits as allowances and pensions. The study disclosed that the majority of patients had inadequate or erroneous information regarding these benefits.

EMOTIONALLY CHARGED SUBJECT

There is a great need for cancer patients and their families to talk with someone who can discuss such an emotionally charged subject from a realistic viewpoint. The need for a relationship which gives support within the confines of reality, but which holds forth no false hopes was demonstrated in these cases.

When cancer involves the brain it becomes difficult for a man to handle his own affairs. One patient in the study group could have been cared for in a nursing home but his impaired judgment made it impossible for him to file for the benefits which would have provided the necessary funds without the help of the medical social worker.

Impaired judgment, however, does not necessarily stem only from organic causes. Fear can produce the same incapacitating effect. Among patients who are undergoing tests which may later confirm their tentative diagnosis of incurable cancer, fear of the mysterious illness for which they are getting no medication reveals itself in many ways. "They don't tell me nothing . . .", becomes a familiar phrase. On a ward where many patients exhibiting the same symptoms are whispered to have cancer, fear is an understandable reaction.

If such fear paralyzes a patient to the degree that he cannot handle his personal or business affairs, he needs help. If this help can result in a renewal of self-confidence, the patient often reveals his desire to know the truth about his physical condition. It is important that such patients be encouraged to express their concern to their physician so that they may learn as much of the truth as the latter believes they can absorb and still maintain adequate ego functioning. One must never under-estimate the strength a husband and wife may then be able to give each other, or the comfort and sustaining power that the warmth of a closely knit family can offer.

Furthermore, the transfer of property, the making of a will,

Ellen Saunders is a clinical social worker, Veterans Administration Hospital, Long Beach, Calif.

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even the legalization of a common-law marriage must often be accomplished during these last few months. Inasmuch as the cooperation of the patient is essential in accepting and working out these vital situations, what he knows about his condition may be all-important.

PATIENTS IN HOSPITAL

Emotional support is frequently needed by those individuals who never leave the hospital either because of the severity of their illness or because of limited finances. Such patients may need help with many diverse problems. This is particularly true when the patient is separated from friends and family.

On a ward where the resident physicians change frequently, the medical social worker is usually one of the few people—aside from nursing personnel—whom such a patient has known continuously throughout his illness and in whom he may feel free to confide. Locating relatives, supplying funds for incidental expenses, aiding in filling out applications for benefits, helping to make a holographic will or arranging for the care of personal belongings are only a few of the services such a patient may need.

Since many of these problems can assume exaggerated importance in the eyes of an ill man, prompt attention to them often means the difference between a contented patient and a distraught one. Furthermore, a man lying in a hospital bed day after day—often with little or no pain but aware of his ever-increasing weakness—needs someone who understands that fear may be at the bottom of his irritability, vague discontent, or extreme dependency on hospital personnel.

Social casework shortened the hospital stay for 5 of the 14 men in the study who were able to be discharged or furloughed. Such supportive treatment, which can motivate a patient into leaving the hospital or his family into caring for him, is important to hospital administration. It is equally important to the patient since his desire to return home may sometimes be thwarted by family resistance based on such factors as fear that cancer is contagious, financial inability to provide for the patient, or complete rejection of the stricken individual.

The need for support from the medical social worker often comes at the time when the family or perhaps the patient has been told of the diagnosis. Minds slowed by age or numbed with grief can seldom gear themselves to action without the emotional relief which "talk and tears" can bring.

DISCHARGE PLANNING

Support from the medical social worker in the area of discharge planning can also be very tangible in its nature. Services may range from locating a community resource that will furnish medicine or a hospital bed to explaining to a frightened wife that slightly blood-streaked sputum is apt to be a symptom of this disease.

The fact that 22 of the 24 patients studied were deceased within a year after the study was initiated clearly points up the central problem facing the patient and his fam-

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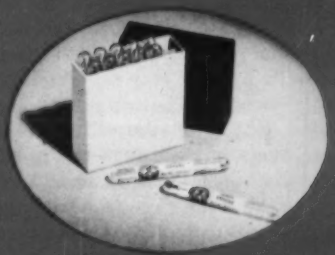

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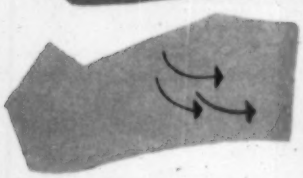

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ily: maintaining the ego strength necessary for adequate functioning in the face of terminal illness and through the readjustment period which the family must experience.

This study showed that 22 patients and/or their families needed help in maintaining such strength and that this help was clearly the kind which called for both casework and an integrated program involving hospital personnel. Aid in financial planning requires the specialized knowledge of the medical social worker.

Emotional support, the other great need, must be given by all personnel who come in contact with the patient. The needs of patients with incurable diseases are met by hospital personnel only if they realize the individual problems each patient may be facing. Only in the light of such understanding can hospital personnel assess properly the complaints of querulous patients or recognize the motivation which may lie behind the "unreasonable behavior" of a distraught family. ■

NOTES AND COMMENT

Principles in care of influenza patients

Uncomplicated cases of influenza do not, in general, require hospital care. However, some cases will be admitted to hospitals for one reason or another. Hospitalization can expose these patients to numerous additional infections.

The guiding principles in the care of these patients are few and simple. They involve few, if any, changes in hospitals already practicing good aseptic techniques and housekeeping.

In the first place, patients with uncomplicated influenza should not be exposed to secondary infections. Influenza cases with communicable complications, such as one of the bacterial pneumonias, should be isolated from other influenza cases. Persons with different kinds of infectious complications should not be grouped together. This consideration requires special attention to the proper placement of the patient on admission.

Members of the hospital staff are also potential sources of infection. Procedures should be established for detection of infections among personnel and the removal of infected persons from contact with patients.

Ideally, patients with infections transmissable by the respiratory tract should be placed in separate rooms. If there are a number of influenza cases, however, there is no reason for their not being placed together in a ward or in a separate building. If a patient shows signs of other communicable diseases he should be promptly isolated from the other cases.

No special aseptic techniques or housekeeping practices are needed beyond those that every hospital should be practicing routinely. It is advisable to review current procedures to see if they are sound in principle and if they are actually being applied. Simple precautions such as washing one's hands before and after contact with a patient are extremely important but often neglected.

Each patient should have his own equipment, especially his own thermometer. Gowns should be worn by all personnel entering the room, but there is no need to change a gown when caring for several patients in the same unit. Gowns should be removed and discarded by persons leaving the unit, however.

Masks are not recommended. They are of unproven value and may be a source of infection unless they are changed when they have become wet or contaminated. In any event, masks should be changed at least every half an hour; they should cover the nose and mouth.

Disposable tissues should be used for discharges from the respiratory tract. When the patient is discharged, only usual procedures are necessary in caring for the room, equipment and supplies.

The staff, along with patients for whom there is no medical contraindication, should be vaccinated against influenza.

In order to develop sound procedures and to make certain that the hospital staff practices these procedures, a special committee to review these matters should be organized. The value of such a committee will be felt not only in the present influenza situation but also in the prevention and control of other problems such as staphylococcal infections.—ROBERT M. ALBRECHT, M.D., *director, Bureau of Epidemiology and Communicable Disease Control, New York State Health Department.* ■

Bacteriologist commends presterilization trend

A leading British bacteriologist highly commended the new trend toward presterilized medical and surgical equipment in the United States in a recent lecture at Seton Hall College of Medicine and Dentistry, Jersey City, N.J.

Lawrence P. Garrod, M.D., bacteriologist to the City of London, said, "The manufacturer, working on a large scale and under perfect conditions, is more certain to do the job of sterilizing properly than any user, and reliance on such materials should remove a serious risk from the practice of both surgery and medicine."

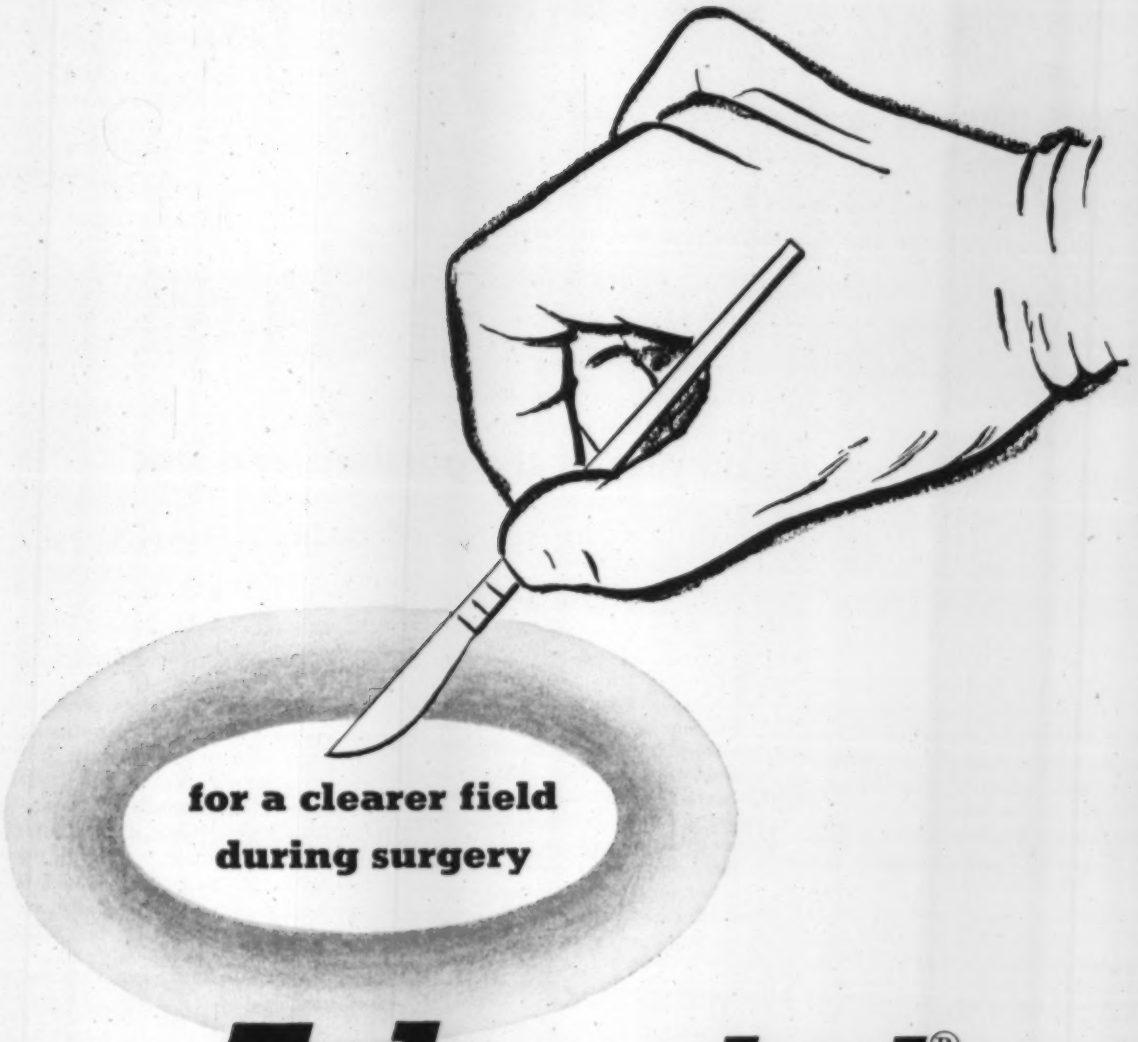
Catgut is the outstanding example of a material which should be sterilized by the manufacturer and not by the user, he said.

Reporting on "some difficult things to sterilize," Dr. Garrod cited the marine sponge as a case in point. "Either autoclaving or formalin will harden and spoil it," he said, while the traditional sterilization method used in England leaves a "profuse growth" of sporogenous bacilli. "I suspect that the answer may be found in ethylene oxide," he reported.

Scalpel blades, which are usually made of ordinary—not stainless—steel, are often damaged in sterilization by slow oxidation, he said. Dr. Garrod offered this suggestion:

"Why not sterilize scalpel blades by dry heat in a sealed metal container in an atmosphere of nitrogen? They could perhaps remain in this (container) and be delivered as required by a device like a razor blade dispenser."

Dr. Garrod's lecture was the first of a series on various sterilization techniques in current use, sponsored by a surgical supplies manufacturer. ■



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purchasing

duties of the purchasing agent in planning for disaster

by WILLIAM SLABODNICK

The purchasing agent's role as a member of the disaster planning committee is a particularly difficult one, the author states, because he is expected to set up standards in an area where even the experts are nebulous in their thinking. Compiling a complete list of sources for items on the disaster supply list is among the purchasing agent's responsibilities in disaster planning.

THE NEED FOR disaster planning is no longer idle talk of the "do-gooder". Hospitals are having it brought home to them forcefully that indecision and lack of planning for disaster situations can be disastrous professionally and costly from a public relations standpoint.

Many considerations enter into disaster planning—organization and control, communications, personnel, inventory of resources, agency support, education of the hospital publics, geographical location, traffic control, security, supplies, mass feeding—to name a few. But from just these few, it can readily be seen that disaster planning is no easy project.

Let us suppose, now, that the administration of a hospital has undertaken the formulation of a disaster program. Committees have been appointed, objectives have been stated in writing, and the wheels are now in motion. The purchasing agent has been oriented to the need, the urgency and the wisdom of preparing for any eventuality. A good beginning is to define what the hospital considers a disaster. One definition that has found wide acceptance is as follows:

"A local disaster is any situation in which the victims reach the hospital in such numbers, or so concentrated in a period of time, or with such severity of injury or disturbance that their prompt, adequate hospital care creates demands upon the hospital which cannot be met by the hospital's routine treatment or admission procedures. Such a disaster may be sudden, one that strikes with little or no warning, such as a tornado, an explosion, a wreck, or it may be forewarning in nature, such as a flood, a hurricane or an epidemic."

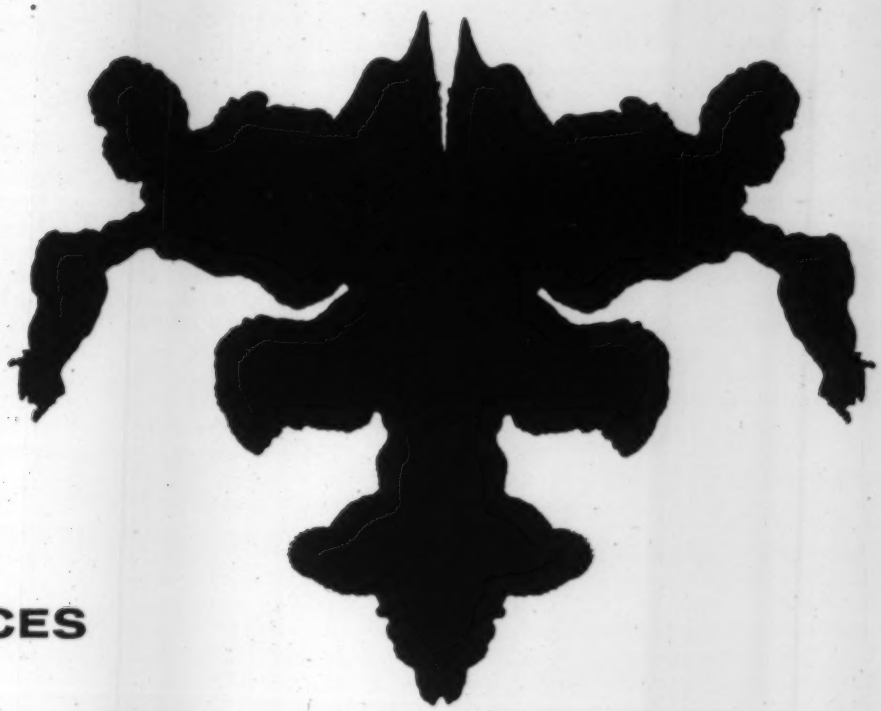
Now the questions begin. How many casualties will have to be taken care of? What supplies will be required and in what quantities? What about storage space, inventory controls, budget, records, and a host of other factors? The answer to the first question about the number of casualties is anybody's guess, since it is not known whether the disaster will be flood or fire, tornado or explosion. However, the disaster planning committee should be able to determine at least the *maximum* number of patients that the hospital can effectively care for. This is not much to go on, but it is a beginning.

The problem is made more complex by the fact that it cannot be foretold what *kind* of patient the hospital will be primarily concerned with. This, too, must depend largely on the type of disaster. The specific requirements of the surgical or orthopedic patient are far removed from those of the medical patient.

STANDARDIZATION

The medical staff, in cooperation with the disaster committee (which should, incidentally, have representation from the staff) should agree on standardized procedures in the treatment of certain types of casualties. Burn treatment is a good case in point. Ten doctors may differ in as many ways as to how to treat a particular burn case. This is, of course, a medical judgment and it is not within the province of the layman to disagree. In a disaster situation, however, these

William Slabodnick is assistant administrator of Massillon (Ohio) City Hospital. This article is based on a presentation at the Institute on Purchasing conducted by the Ohio Hospital Association in Columbus, Oct. 24-25, 1957.



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variances in treatment are a luxury that hospitals and the doctors themselves can ill afford. Standardized, acceptable treatments are imperative so that at least the *kind* of supplies that will be required can be anticipated.

Pharmaceuticals present another area where standardizations, if they do not already exist, should also be considered. One kind of penicillin and perhaps two or three other basic antibiotics can be stocked for emergency use rather than the many varieties often making up the pharmacy inventory. Medical supply lists should be a joint responsibility of the medical and nursing staffs as well as the directors of the ancillary services within the hospital. Procurement remains the responsibility of the purchasing agent. If the professional groups can anticipate their needs, there is little reason why the purchasing agent cannot have at least a representative quantity of an item on hand when it is needed.

STOCKPILING FOR DISASTER

The feasibility of stockpiling supplies in hospitals as part of a disaster plan is open to debate. In some programs, a great deal of emphasis was placed on filling chests, boxes and cartons with supplies of every description and placing them in strategic locations throughout the hospital to be used in case of a disaster. In most instances these "disaster packs" are clearly labeled with complete listings of the contents. Personnel were oriented in their use at the time they were made up, but with constant turnover the subject may have been forgotten. It is highly likely that even the location of the pack has been forgotten. This has been known to happen. Or again, at a critical moment it may be discovered that the contents list bears no relationship to the actual content of the pack because items "borrowed" were not replaced, leaving a pack of little value. Meanwhile, tucked away in these units are hundreds of dollars worth of supplies that may be obsolete or in a deteriorated condition.

It would seem that these critical items could be properly stored in a section of a central storeroom clearly marked for disaster use. This location should be known to all supervisory personnel and be open at all times.

The storekeeper and the purchasing agent should check these supplies periodically to see that they are properly rotated and immediately replaced with fresh stock. This system would prevent loss due to deterioration and would also insure that usable supplies are on hand at all times. Freshness is especially important with antibiotics and certain types of prepackaged sterile supplies. The purchasing agent should go over the supply lists at least annually with the professional staffs to determine which supplies, if any, should be deleted or added to the list.

The most heartening truth in disaster planning is the knowledge that no hospital need stand alone. Few hospitals indeed are so far removed from civilization that they cannot be reached within a matter of hours even under the most trying circumstances. All hospitals carry enough medical and surgical supplies to carry them through a few hours of a critical situation. The source of supply should be known for every item on the disaster supply list, and how long it will take to get a rush shipment at the least convenient time. (Obviously the supplier could give better service at 2 p.m. than at 2 a.m.) The time lag between the emergency order and the delivery will assist the purchasing agent in planning his inventory. With present air transportation systems it is highly unlikely that a hospital could not get an emergency delivery of a critical item within a very few hours even from a distant source.

An accurate, up-to-the-minute listing of sources for items on the disaster supply list should be posted in the storeroom and be made available to the purchasing agent and the administrator. It should include:

1. Names of at least three persons connected with each source, along with addresses and telephone numbers for contacting them both night and day. These persons should have access to warehouses where supplies are kept. This list may include (a) hospital supply houses, (b) wholesale drug companies, (c) major drug companies, (d) key salesmen of these companies in the hospital's area, and (e) drug stores.

2. Hospitals in neighboring communities. It should be kept in mind that other hospitals in the community in which the disaster has occurred will probably be facing emergencies of their own and may not be able to lend much assistance.

3. Names and telephone numbers of agencies that may be able to provide transportation if needed. These agencies may include (a) local and state police, (b) local civil defense officials, and (c) American Red Cross.

4. Telephone numbers of local newspapers and radio and television stations.

UTILITIES

Responsibility for maintaining heat, light, and power should remain with the maintenance department of the hospital. If a disaster plan is to be successful it must first be based on an achievable goal, and this means placing responsibilities with those best equipped to handle them. The purchasing agent is not entirely separated from these areas, for there are certain items that the maintenance force must be provided with. Fuel for operating standby power equipment is one example. The best standby generator without fuel to operate it is in itself a major casualty. The chief engineer is the person most qualified to estimate his emergency supplies.

Another critical supply item is blood. Blood procurement should be the responsibility of those normally entrusted with this function. In most hospitals this is done by the laboratory or the blood bank if there is such a department. It is vital that the hospital make immediate contact with the source of blood supply as soon as a disaster alert has been sounded.

Many a hospital has set up a disaster plan and completely forgotten about enlisting the assistance of outside agencies. There are agencies in every community that are ready and able to help the hospital in many ways in times of stress. A program which does not integrate and coordinate

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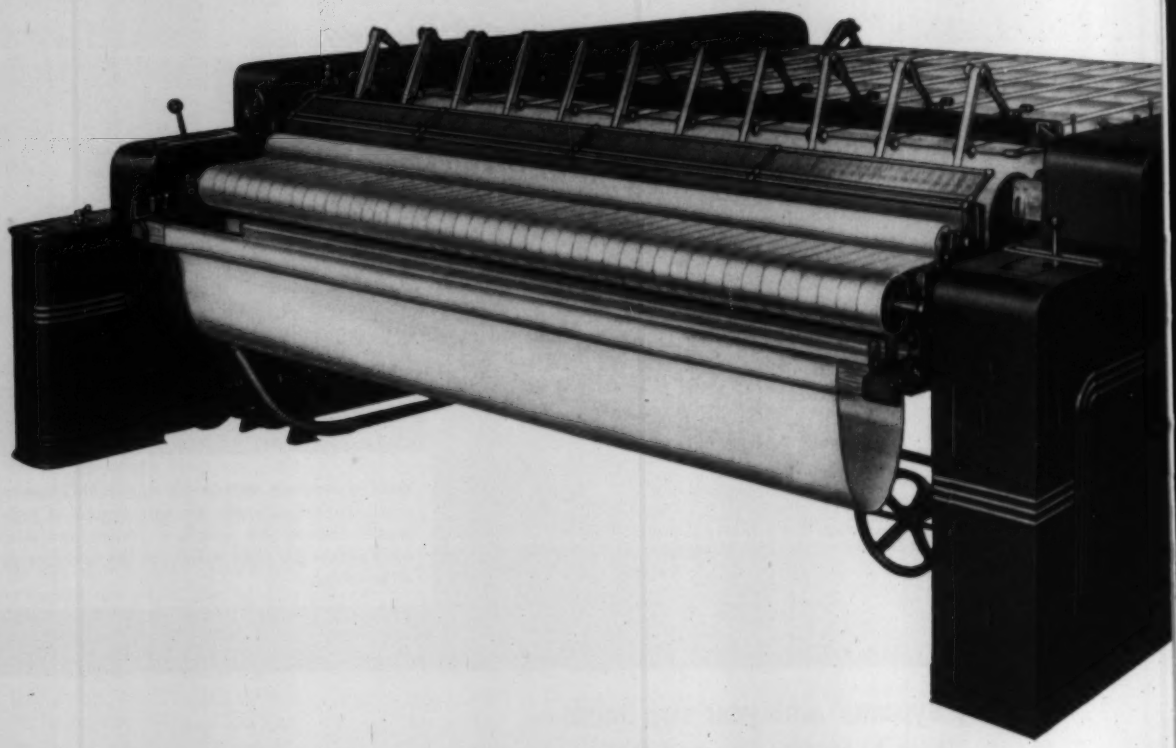

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civic and public agencies in the hospital disaster plan is not making use of all resources. Cots and blankets may be available through the local Red Cross chapter. (If this is not true, it might be well for the hospital to purchase a number of canvas cots and store them at the hospital.) Portable battery communication sets may be available through local civil defense authorities. Planning for items such as these should be done before the need presents itself.

Two items not regularly stocked by the hospital that will be necessary in a disaster situation are large paper shopping bags that can be used for patients' clothing and valuables, and identification tags that can be affixed to all arriving casualties. To keep regular hospital admission records during the period of the emergency is neither practical nor necessary.

On the other hand, supply records are important. The purchasing agent and storekeeper should devise some system for rapid issue of supplies to patient care units. Because speed is essential, the requisitioning system should be free of red tape. A little common sense will go a long way toward making the job much more pleasant and productive, and it may go far in saving lives.

Delivery of supplies should be delegated to personnel not normally assigned to the storeroom. Obviously these persons must know the hospital. Storeroom personnel should remain at their posts in order to carry out the major function of making up orders as they are received. In the interest of speed, telephone orders should be considered.

SUPPLIES ACCOUNTING

If the purchasing department maintains a perpetual inventory system, the supply of any item can be quickly determined, but at the same time such a system places a greater emphasis on the need to account for everything that leaves the storeroom. It is also possible that the hospital may receive some financial assistance for supplies used from the Red Cross and government sources under mass care programs, particularly if the area is designated as a disaster area. Under these circumstances adequate cost studies can be carried out only if proper accounting has been maintained.

To facilitate the keeping of records on the receipt of borrowed and donated supplies, all deliveries of these items should be made to a specific place. The administrator no doubt will want to know what persons or agencies were involved so that a letter of thanks can be sent at some future date. The public relations responsibilities of the hospital cannot be overlooked even in disaster planning.

To summarize, the task of the purchasing agent as a member of the disaster planning committee is a particularly difficult one. He is expected to set up standards in an area where even the experts are nebulous in their thinking. Because of the number of variables, disaster planning lends itself more easily to subjective rather than objective thinking. It is apparent that nobody has all of the answers; perhaps we don't even know all of the questions. ■

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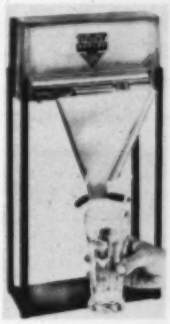
equipment and supply review

Shock therapy bed (2C-1)
Manufacturer's description: This new shock therapy bed is manually operated. It can be raised to treatment-table height and lowered to a safe and convenient position for the care of the patient in the shock

therapy recovery room. The bed is used to transport patients between treatment rooms and recovery rooms. A flat fabric spring is used; shock treatments and recovery room care can be given with the patient in a horizontal position. A foam rubber mattress 4 in. deep gives a sleeping surface of 28 by 78 in. *Hill-Rom Co., Dept. H, Batesville, Ind.*

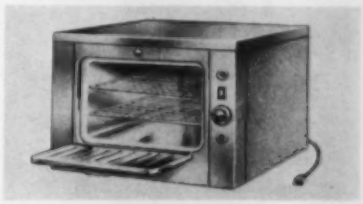
Straw dispenser (2C-2)
Manufacturer's description: Stainless steel dispenser automatically drops an unwrapped straw directly into a glass. The dispenser mounted on an all-steel stand, eliminates the use of wrapped straws. Unwrapped straws cost less than half of those that are wrapped. The unit saves on space by eliminating the use of straw holders. It holds a full carton of unwrapped straws. *Duplex Straw Dispenser Co., Dept. H, 500 N. La Cienega Blvd., Los Angeles 48, Calif.*



Steel cabinets (2C-3)
Manufacturer's description: This line of steel cabinets includes storage cabinets, combination storage and wardrobe cabinets, desk-height efficiency cabinets and counter-height utility cabinets. The cabinets feature smooth, streamlined exteriors, three-point security latching, chrome door handles, built-in grooved key locks, attractive cornice tops, nonsagging doors, flush hinges and adjustable shelves. Constructed of heavy gauge steel,

the cabinets are finished in oven-baked enamel, electrostatically sprayed over a special corrosion resistant, zinc-iron-phosphate undercoat. *Penco Metal Products Div., Dept. H, Alan Wood Steel Co., 200 Brower Ave., Oaks, Pa.*

Food warmer (2C-4)
Manufacturer's description: Food warmer requires no installation and is designed for use in every type of feeding operation. The unit will hold hot food for hours without permitting it to dry out or to pick



up additional moisture. It provides accurate, dependable control of temperatures from 100°F. to 300°F.

An endeavor is made to screen carefully the products appearing in this section. However, the statements printed have been made by the manufacturer and are brought to your attention primarily to keep you informed of new developments in the field. —The Editors.

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 18 E. Division St., Chicago 10, Ill.

PRODUCT NEWS

- ____ Shock therapy bed (2C-1)
- ____ Straw dispenser (2C-2)
- ____ Steel cabinets (2C-3)
- ____ Food warmer (2C-4)
- ____ Upholstered commode-chair (2C-5)
- ____ Water-cooled electric plants (2C-6)
- ____ Nebulizer-humidifier (2C-7)
- ____ Tray server (2C-8)
- ____ Locking button (2C-9)
- ____ Equipment ensemble (2C-10)
- ____ Tissue-thin gloves (2C-11)
- ____ Motorized bed (2C-12)
- ____ Air filter (2C-13)

PRODUCT LITERATURE

- ____ Hospital equipment (2CL-1)
- ____ Junior spectrophotometers (2CL-2)
- ____ Electric motors (2CL-3)
- ____ Microradiography (2CL-4)
- ____ Waste receptacles (2CL-5)
- ____ Food line (2CL-6)

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It features an interior compartment construction of stainless steel. The door is ribbed for extra strength and is equipped with stainless steel stop hinges. Within each compartment are two removable chrome plated wire shelves. *Franklin Products Corp., Dept. H, 400 W. Madison St., Chicago 6, Ill.*

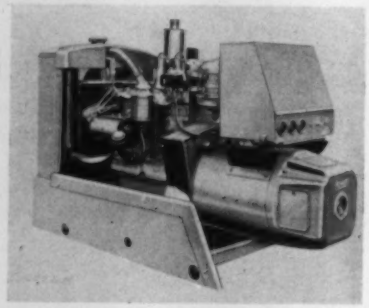
Upholstered commode-chair (2C-5)

Manufacturer's description: Chair enables purchaser to buy a modern upholstered chair and a commode, all in one, thus saving space and eliminating old-fashioned commodes. This commode-chair is a

plastic upholstered arm chair with chrome arms and legs, and a baked enamel body. The entire chair and commode is washable, including the plastic upholstery, thus assuring easy maintenance and maximum cleanliness. The upholstered seat is hinged to the body of the chair so it can be lifted. The wood seat underneath is also hinged to the metal chair body so that the wood seat can be raised for easy removal of the baked enamel receptacle for emptying. *Arlington Medical Co., Dept. H, 11 N. State Rd., Arlington Heights, Ill.*

Water-cooled electric plants (2C-6)

Manufacturer's description: Savings of up to $300 are claimed for these water-cooled, revolving-armature 10 and 15 kw. electric plants. This new series is available in either 10,000 or 15,000 watt a.c. size ranges in voltages to 460 volts. These gasoline engine driven units will provide full-rated electric power for all types of standby



emergency applications. The units are water cooled with a 41 h.p., four-cylinder engine. *D. W. Onan & Sons Inc., Dept. H, Minneapolis, Minn.*

Nebulizer-humidifier (2C-7)

Manufacturer's description: Nebulizer-humidifier features automatic 40 per cent oxygen limitation for incubator use. It can be used with all types of oxygen therapy equipment, oxygen masks and tents and tracheotomy equipment. Providing humidity of 100 per cent saturation and/or nebulization of

medications in fine mist for respiratory disorders, the unit also includes a nonbreakable plastic bottle with a 500 c.c. capacity for prolonged use, operating easily with an oxygen or air supply. *Continental Hospital Industries, Inc., Dept. H, 18624 Detroit Ave., Cleveland 7, Ohio.*

Tray server (2C-8)

Manufacturer's description: The tray server vacuum-seals and protects

freshly cooked hot entrees for over one hour when used with any china

dinner plate up to 9½ in. in diameter. It is made up of only three elements: a tray and dome cover, both molded from shock and heat-resistant tough plastic; and a "heat battery"—a disc of pyrex glass that is preheated before placement in the unit. The tray server works with any traycart that takes a tray size of 16½ in. by 22½ in. and an over-all height of 5 in. *Mealpack Corporation, Dept. H, 2014 Ridge Ave., Evanston, Ill.*

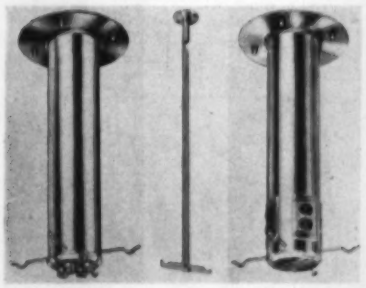
Locking button (2C-9)

Manufacturer's description: New locking button for hospital bedside calling

service is virtually unbreakable and suitable for use with any make of cord set. Extremely high resistance to crushing and physical shock is provided by means of a molded nylon shell. The button will not break when dropped or stepped on. A strain relief design permits free turning shell and cord to prevent shorting or breaking of connecting cords. Because the means for resetting is obvious to the patient, accidental resetting is eliminated. *Edwards Company, Dept. H, Norwalk, Conn.*

Equipment ensemble (2C-10)

Manufacturer's description: These overhead installations for gases, vacu-



um, intravenous and electrical services provide more efficient use of existing floor area in surgical and recovery rooms. The overhead location facilitates safe and free movement of traffic pattern and provides the patient with the

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security of safe, sanitary operation. The three products are an overhead surgical gases dispenser unit, an overhead intravenous hook and an overhead electrical unit with intravenous hooks installed. *Logan Hospital Equipment Co., Dept. H, P.O. Box 751, Glendale, Calif.*

Tissue-thin gloves (2C-11)

Manufacturer's description: These gloves are thinner than the sheerest surgical glove and are textured inside to slip on quickly without talcum. The gloves are reversible to give a nonslip grip on the outside

when required and have curved snug-to-tip fingers. Called "nimble fingers," they have high nonallergic properties that offer relief to persons allergic to rubber. *The Pioneer Rubber Co., Dept. H, Willard, Ohio.*

Motorized bed (2C-12)

Manufacturer's description: Control allows bed to be operated by a switch held in the hand. The switch oper-

ates head and foot sections independently and also raises or lowers the height of the bed. Patients can make slight adjustments in position themselves without calling the nurse. If the patient is not allowed to change his own position, cut-off switches are provided to inactivate either or both sections of the spring. The quiet, efficient ¼-h.p. motor is fully enclosed and of the induction type. Underwriters Laboratories approval has been applied for. *Simmons Company, Dept. H, Contract Department, 1870 Merchandise Mart, Chicago 54, Ill.*

Air filter (2C-13)

Manufacturer's description: This new air filter operates on an electrostatic principle. Movement of air through the filter builds up and maintains an inherent electrostatic charge on the woven plastic fabric surfaces of the filter. Charged particles are attracted to oppositely charged plastic surfaces, just as a magnet attracts iron filings. Dust, dirt, pollen and sooty particles are held in the electro-

static trap with the filter collecting up to 2½ times as much dirt as ordinary filters. *Stoddard Industries, Inc., Dept. H, 1545 N. Kingsbury, Chicago, Ill.*

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product literature

SEE COUPON, PAGE 69

Hospital equipment (2CL-1)—Twelve-page folder lists various hospital equipment ranging from washable pillows and wet-proof mattresses to patient room accessories and hospital furniture. Pictorial and written descriptions are accompanied by prices. *A. S. Aloe Co., Dept. H, 1831 Olive St., St. Louis 3, Mo.*

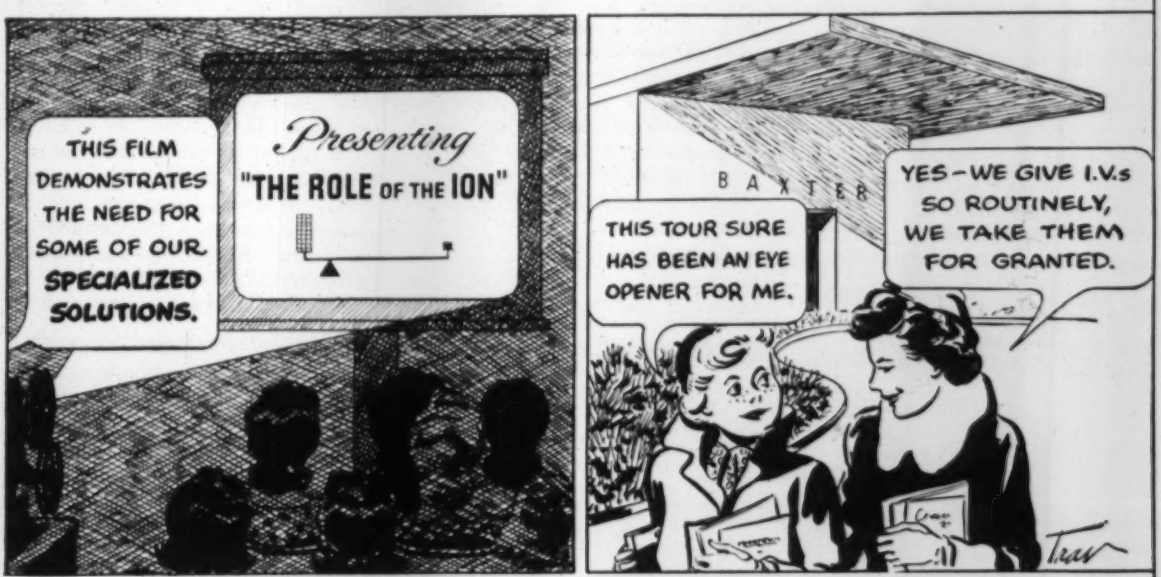
Junior spectrophotometers (2CL-2)—Folder describes a line of spectrophotometers, giving model specifications. Thorough description of various models is accompanied by photographs. Features of the instrument as applied to the chemist are also given. *Physicians and Hospitals Supply Co., Dept. H, 1400 Harmon Place, Minneapolis, Minn.*

Electric motors (2CL-3)—Ten-page booklet describes the basic fractional-horsepower motor types and designs currently being manufactured by the company. Detailed description accompanies each photograph picturing the various models. Features of open and totally enclosed motor construction are also presented. Mechanical variations, including jet pump motors, oil burner motors, gear motors, unit heater motors and brake motors, are also given. *Century Electric Co., Dept. H, 1806 Pine St., St. Louis 3, Mo.*

Microradiography (2CL-4)—New 48-page booklet entitled "Principles of Microradiography" includes a bibliography on the subject of microradiography and soft x-ray radiography. One section is devoted to the principles of microradiography and discusses contact and projection techniques together with x-ray microscopy. Other subjects covered include: geometrical blurring, increasing contrast with photographic material and photomicrographs. *Instruments Division, Philips Electronics, Inc., Dept. H, 750 South Fulton Ave., Mount Vernon, N.Y.*

Waste receptacles (2CL-5)—Catalogue introduces a new line of drum tops and new sanitary napkin wall receptacle. Shows how drum tops can convert any 50-gallon drum into a self-closing waste receptacle. Catalogue also fully illustrates and describes the company's complete line of self-closing and drop-in waste receptacles, garbage can enclosures, toilet tissue and paper towel dispensers. *Bennett Manufacturing Company, Inc., Dept. H, Alden, N.Y.*

Food line (2CL-6)—Many new food products are described and illustrated in this folder. Products include cheeses, salad dressings, jellies, pickles, shortening and margarine. Details are given on varieties, costs and handling. *Kraft Foods, Dept. H, 500 N. Peshtigo, Chicago, Ill.*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laundry-housekeeping

a practical approach to lower laundry costs

by ROBERT GUY

TOP: The single extractor in the laundry at Baton Rouge General Hospital was adequate for the laundry's two washers but would not handle the maximum capacity of the needed three washers. ABOVE: New 375-pound extractor is equipped with a crane for lifting baskets.

The author reports on a study of laundry equipment and procedures carried out at Baton Rouge General Hospital in the face of an increase in bed complement. The study resulted in the purchase of new laundry machinery, a reduction in the number of employees, and a substantial lowering of production costs.

STUDY of the laundry operation at Baton Rouge General Hospital began during a construction program which was to add approximately 100 beds and increase the hospital's bed complement from 250 to 350 beds. In considering the impact of 100 more beds upon the various departments, it was necessary to determine whether or not the laundry would be adequate for the increased work load. The study was approached as largely a matter of applying common sense and taking advantage of a second resource—that of calling upon industrial leaders of the community for advice.

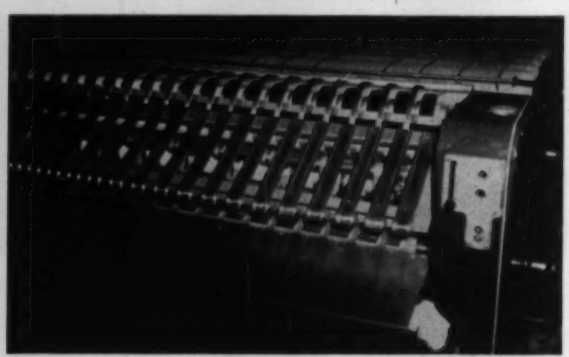
Baton Rouge General Hospital is situated in a highly industrialized city. The hospital has long been in the favorable position of being able to call upon industry for assistance in many ways. Industrial leaders are on the board of trustees and advisory committee. No attempt has been made to "run the hospital" nor has industry sent men into the hospital to make special studies, but the hospital has been able to call upon industry's highly trained technical people to advise and train members of its administrative staff. Thus studies of methods and procedures and initiation of new programs have been carried out by hospital personnel.

Robert Guy is administrator of Baton Rouge (La.) General Hospital.

WHO HEADED STUDY

The present study was headed by a hospital staff administrative assistant whose primary duty is to make special studies in various departments and to recommend changes which will result in more efficient operation and more effective use of personnel. The person who fills this position has an undergraduate degree in business administration and was employed part-time in the hospital while completing his last three years in college. He has had no special

OLD four-roll flatwork ironer in the hospital laundry was not usually operated at maximum speed because of inadequate steam supply.



NEW eight-roll flatwork ironer has an automatic folder. The old folder would have been adequate for two or three shifts but not for one.

training in preparation for his present assignment.

In making this study of the laundry, it was recognized that procedures used in industry can be applied advantageously in hospitals. One of the most effective methods used by industry to hold down costs is to reduce the personnel force. This same method can be used in a hospital, particularly in departments not directly involved in the care of patients. The study of Baton Rouge General's laundry resulted in the purchase of new laundry machinery, a reduction in the number of employees, and a substantial lowering of production costs.

When the laundry was built in 1951 the equipment installed could process 50,000 pounds of laundry a month, operating on one shift a day and 44 hours a week. Within three years it was being operated beyond this capacity and another shift of workers had been added. At the time this study was initiated the laundry was producing 80,000 pounds a month in two shifts totaling 85 hours a week. The machinery, obviously, was not being utilized to its full capacity, but the load could not be increased without first determining what maximum output could be expected from the equipment. If the equipment could not absorb the increase, then the alternative would be to add another shift or purchase larger machinery.

FIRST STEP OF STUDY

The first step was to determine the utilization of the existing washing machines and the flatwork ironer. It was found that the large washer (225) pounds capacity) was utilized approximately 51 per cent of the time available. The small washer (50 pounds capacity) was utilized 75 per cent of the time. These percentages were determined as follows:

Allowing for meal periods, rest periods, breakdowns, individual skills, etc., it was concluded that not more than 80 per cent utilization could be expected at best, with the remaining 20 per cent considered a leveling factor. Thus it appeared that 17 per cent of possible washing time was being lost. This wastage was traced to the fact that the washman frequently overwashed the loads. (The washers were not equipped with automatic timing devices, so that the washing period was left to the judgment of the washman.) It was also found that both machines often were stopped at the same time, so that one washing machine stood idle while the other was unloaded. These were evidences of inefficient washing procedures. It was found, too, that not enough carts were available for wet linen, a situation which also contributed to inefficient procedures. These were not all of the faulty methods that were uncovered, but they are representative of the kind of inefficiencies noted.

In a two-week period (170 work hours) 116 loads were produced in the large washer. Allowing 45 minutes to a load, the washer was in use 87 washing hours or 51 per cent of the total work hours available.

The two washers together were in operation 214.5 washing hours. Out of 340 work hours (170 hours

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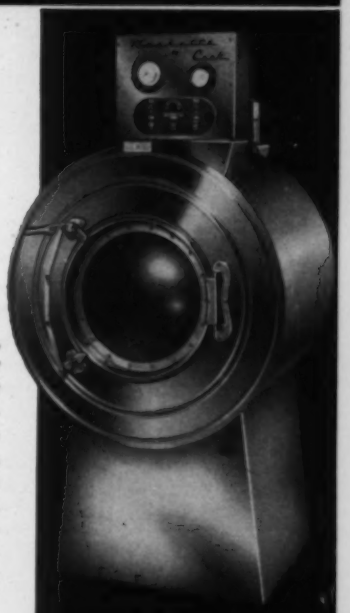

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for each washer) the utilization was 63 per cent.

SECOND STEP

The next step in the study was to determine the maximum capacity of the two washers. The laundry was operating 85 hours a week, or 368 work hours a month:

$$\frac{85 \text{ hrs.} \times 52 \text{ wks.}}{12 \text{ mos.}} = 368 \text{ work hours.}$$

Again allowing 45 minutes per load, 490 loads a month could be expected from each washer:

$$\frac{368 \text{ work hrs.} \times 60 \text{ min.}}{45 \text{ min.}} = 490 \text{ loads}$$

Taking into consideration the 20 per cent leveling factor, both washers could be expected to produce a maximum of 107,800 pounds of linen a month.

392 (80 per cent of 490) x
225 (washer capacity) = 88,200 lbs.
392 (80 per cent of 490) x
50 (washer capacity) = 19,600 lbs.

per mo. 107,800 lbs.

Raising the complement to 350 beds and anticipating an 80 per cent occupancy would mean an average daily census of 280 patients, an increase of 40 per cent over the daily average then current. An increase of 40 per cent over the 80,000 pounds a month production before the expansion program would call for a washing capacity of at least 112,000 pounds a month, an average of 13 1/3 pounds a day per patient In round numbers it appeared that the load would exceed the maximum capacity of the two washing machines (operating two shifts) by at least 4000 pounds a month. Actually, it was felt that this "over capacity" figure would be exceeded by several thousand pounds—too much to anticipate doing on an overtime basis.

The laundry was equipped with a four-roll flatwork ironer, two complete pressing units, an extractor, and two tumblers. The flat-work ironer was in use approximately 80 per cent of the work hours available, but was not usually operated at full speed (48 feet a minute). Study showed it was operated at about three-fourths its maximum speed because some linens—sheets in particular—came out damp when the speed was set at 48 feet per minute. Because this factor reflected an insufficient steam supply, it was felt that the problem would be eliminated by the installation of a new steam boiler included in the construction contract. Even so, the ironer, like the washers, would not have enough capacity for a 40 per cent increase in work load if it was operated only two shifts.

EXTRACTOR TOO SMALL

The laundry's one extractor (125 pounds capacity) required a running time of 12 minutes per load. This machine was adequate to handle the maximum capacity of the two washers, but it would be too small if a third washer were added.

The two pressing units were operated approximately 60 per cent of the available time on the two shifts. One operator on the evening shift worked part-time on the flatwork ironer. The units were used for pressing uniforms of lower salaried employees, practical and professional student nurses, and student technicians. Based on information available from the laundry machinery manufacturers as to the normal output of one operator, this equipment was thought to have ample capacity for the increased load if operated either two or three shifts. If the operation were to be reduced to one shift, another complete pressing unit would be necessary.

At the time of the study, the 19 laundry employees were assigned as follows:

Classification	Day	Evening
Manager	1	
Student supervisor		1
Washman	1	1
Linen man	1	1
Flatwork ironers	4	4
Pressers	2	2
Utility operator	1	
	10	9

DECISION ON SHIFTS

Study of the laundry equipment indicated that the washers and flatwork ironer, operated on two shifts, would not have sufficient capacity for the increased work load. A decision had to be made between operating on three shifts or purchasing equipment of sufficient capacity to operate on one shift. Operating on two shifts was considered undesirable and an "around the clock" operation highly impractical.

Analysis of laundry equipment data from two manufacturers led to the conclusion that purchase of the following equipment would make it possible to operate on a one-shift basis with capacity to spare: one additional washer (350-pound capacity) with automatic controls, an eight-roll ironer with automatic folder, an extractor (375-pound capacity) with a crane for the extractor baskets, and one additional pressing unit. Automatic controls would also be needed for the 225-pound washer. Total cost: $46,000. Personnel requirements were worked out as follows:

Laundry manager	1
Washman	1
Linen man	1
Flatwork ironers	5
Pressers	3
Utility girl	1
	12

Following is a comparison of the actual expense of operations current at the time of the study to the estimated expense of the two alternatives.

OPERATION CURRENT DURING STUDY

250 beds at 80 per cent occupancy (80,000 pounds a month)—two shifts :

Salaries	$25,476.00
Supplies	3,098.31
Workman's Comp. & Soc. Sec.	646.94
Utilities	675.00
Depreciation	3,430.00
	$33,326.25 (act.)

FIRST ALTERNATIVE

350 beds at 80 per cent occupancy (112,000 pounds a month)—three shifts, same equipment:

Salaries	$33,959.00
Supplies	4,130.00
Workman's Comp. & Soc. Sec.	862.00
Utilities	899.00
Depreciation	3,430.00
	$43,280.00 (est.)

SECOND ALTERNATIVE

350 beds at 80 per cent occupancy (112,000 pounds a month)—one shift, new equipment:

Salaries	$16,260.00
Supplies	4,337.00
Workman's Comp. & Soc. Sec.	416.00
Utilities	945.00
Depreciation	5,624.00
	$27,582.00 (est.)

Cost per pound of laundry at the time of the study was 3.5 cents. Cost for producing laundry on three shifts was estimated at 3.2 cents per pound. It was estimated that on a one-shift basis, all of the laundry could be produced for 2.0 cents a pound and that the new equipment could be paid for in three years. The accompanying table gives a clearer picture, in round numbers, of the comparison.

It is too early to access the full benefits of the changes, but the following advantages have already been gained:

1. Equipment is operating on one shift rather than three; therefore, it should last three times as long.

2. The number of employees has been reduced.

3. The operation should be increasingly efficient, since all work is performed under the direct supervision of the laundry manager.

4. Employee productivity is greater, because the work load is sufficiently heavy to keep individual production at a high level for eight hours.

5. There is a 1.5-cent saving on every pound of laundry produced. ■

Table showing comparative laundry costs for three operating systems

Item	Present Operation	First Alternative	Second Alternative
Number of beds	250	350	350
Shifts operated	2	3	1
Personnel required	19	26	12
Pounds of laundry per year	960,000	1,344,000	1,344,000
Cost per pound	3.5¢	3.2¢	2.0¢
Annual cost	$33,300	$43,300	$27,600
Annual savings	—	—	$15,700
Capital expenditures	—	—	$46,000
Pay-out period	—	—	3 yr.

NOTES AND COMMENT

Minimizing loss of tensile strength

The excessive use of bleach in the washwheel is only one of the responsible factors for excessive losses in fabric strength. One may use normal quantities of chlorine bleach per 100 pounds of dry fabric and still attain large losses in fabric strength. These high losses are not due in many instances to the use of chlorine bleach in the washing formula, but rather to improper and inadequate physical conditions at the institution.

One of the most common conditions at many of the institutions is the lack of an adequate hot water supply for laundering purposes. It is not uncommon to find a single hot water generator supplying hot water to the laundry and the remainder of the hospital. As a result, the laundry must resort to injecting live steam directly into the washwheel. Under these conditions, there is a right and a wrong way of using steam in processing linens.

The following "don'ts" should be helpful in minimizing the tensile strength loss in fabrics:

1. Don't use steam once the chlorine bleach has been added to the washwheel. In utilizing steam to acquire the proper temperature on the bleaching operation, always obtain the correct bleaching temperature before adding the bleach to the bath. The use of steam with bleach is very harmful to textiles.

2. Don't use steam on the first rinse operation. A portion of the chlorine bleach is absorbed by the fabrics, and is carried over to the first rinse bath.—JOSEPH KRAWIEC, in American Laundry Digest. ■

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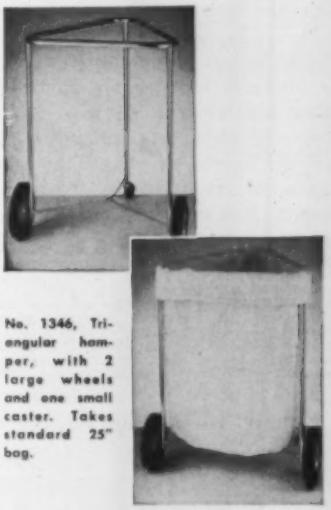

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food service and dietetics

BUDGET PLANNING: how to prepare dietary budgets for large hospitals

by GRACE L. SCHOLZ

Procedures and forms that may be used for setting up dietary budgets in large hospitals are outlined by the author in this second article on budget planning. The first article, which appeared in this department January 1, described budget planning techniques for use in smaller hospitals without the services of a professionally qualified dietitian.

SOUND BUDGET planning is vital to the effective management of any well organized dietary department. Budget planning and food cost control methods, however, vary according to the size of the hospital and to the needs of the individual department. In this article, the budget will be considered in terms of the larger hospital—in terms of a realistic operating plan for the dietary department.

PURPOSE OF THE BUDGET

The purpose of the dietary budget is to enable management to plan its operation in a way that provides distribution of the food dollar according to needs. The budget establishes definite goals to be attained with regard to operating performance. It is a statement of objectives in terms of specific figures. It charts the best course of operation and helps us keep to that course.

The budget assists in the orderly management of funds. It stimulates cooperation and support between the dietitian and other department heads. It allows for current comparisons of certain costs with other departments of the hospital. It promotes maintenance of uniform quality of menus and service.

The budget places the responsibility for planning and the authority for achieving goals with the department head. It gives the administrator reason to recognize the dietitian as an executive and alert administrator. These plans must be realistic and supported by carefully detailed estimates and programs that will make it possible to live within the budget and at the same time serve the desired quality of food. In administering allocated funds, the opportunity for service and recognition motivates the dietitian to utilize funds to the best advantage. It is only human nature to move heaven and earth, if necessary, to make our own plans work. The glow of inner satisfaction that comes when goals are reached will be reflected through the entire department—from the dietitian to the last maintenance man, who found a way to make the cleaning supplies last, when there was no more money until the next quarter. This type of cooperation results only when the entire staff actively participates in the planning and implementation of the financial plan.

Shortages and mistakes that occur through errors in our own planning are easier to live with than those made by another who has no special interest in the dietary department.

DEVELOPMENT OF THE BUDGET

In developing a budget, the dietitian should consult with the administrator or business manager so that the dietary budget will be in line with over-all hospital policies and plans. This includes a firm understanding as to the pricing of the menu and size of portion to be served. If the hospital operates with a budget planning committee, the chairman will be able to provide information regarding anticipated patient load, including seasonal peaks; plans for expansion in bed capacity, or decreases in certain services. If the budget is be-

Grace L. Scholz is chief of the dietetic service at the Veterans Administration Hospital, Hines, Ill. These statements and conclusions are those of the author and do not necessarily reflect the opinions and policies of the Veterans Administration. This article is an adaptation of Miss Scholz's address at the American Hospital Association Institute on Hospital Food Service Supervision in Dearborn, Mich., May 1957.

Chart 1—Staffing pattern for dietary professional personnel

Title	No.	Base Salary Per Annum	Total	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Remarks
Administrative Dietitian								($200 raise every 18 months)
Asst. Administrative Dietitian								($120 per annum raise beginning 3rd qtr.)
Head Dietitian								
Training Dietitian								
Dietitian								
Associate Dietitian								
Sub Total by Quarters								
Total								
Secretary								($60 per annum raise beginning 4th qtr.)
Administrative Clerk								
Typist								
Sub Total by Quarters								
Total								

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ing planned for the first time, it will also be necessary to contact the controller for a list of past expenditures which will serve as a basis for future planning.

It is necessary to develop a questioning attitude in evaluating the dietary operation. Each phase of the operation needs to be analyzed.

Dietitians should ask themselves these questions when requesting funds: Is this activity necessary to accomplish the mission of the department? If it is necessary, can any part be eliminated or combined? Is the utilization of all resources, men, money and materials planned in an organized manner?

After these questions have been answered honestly, it is time to list and catagorize the funds needed. There are a number of formats which may be used. The information may be developed on a monthly, quarterly or annual basis, or by dividing the year into 13 four-week periods. For this discussion, the quarterly pattern will be used.

DIVISION OF COSTS

Once the dietary operation has been analyzed and the format for the budget chosen, the dietitian is ready to forecast food service costs. These costs usually consist of three major divisions: salaries, services and supplies. Each of these divisions may be further divided.

Let us first consider the staffing pattern, since the total personnel budget comprises approximately 80 per cent of the total hospital budget. It is necessary to know and list the number of professional, nonprofessional and clerical workers, including part time and relief workers, who will be employed. Their salaries, annual increments (if such increases are the policy of the organization) and salary distributions per quarter should be itemized (Chart 1, p. 78, and Chart 2, above).

Employee benefits such as night differential, holiday pay, overtime payments for accrued vacation leave at time of resignation, uniform allowance, group hospitalization, life insurance, social security and incentive awards are a part of today's improved employment practices. The expenses incurred by offering any or all of these benefits should be included in the budget. A work sheet for recording costs of employee benefits is shown above (Chart 3).

Chart 2—Staffing pattern for dietary nonprofessional employees

Class Title	Grade	No. of Employees in each grade	Yearly Salary	Total	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Cooks, Supervisory								
Cooks, Supervisory								
Cooks, Supervisory								
Cooks, Supervisory								
Cooks, Diet								
Cooks, Head								
Cooks, Assistant								
Cooks Helpers								
Bakers, Supervisory								
Bakers, Assistants								
Bakers Helpers								
Meat Cutters, Supervisory								
Meat Cutters, Assistants								
Meat Cutters Helpers								
Food Service Workers, Supervisory								
Food Service Workers, Supervisory								
Truck Driver								
Storekeeper								
Food Service Workers								
Food Service Workers								
Sub-total (No. of Employees)		----------						
Within grade pay raises				----------	----------	----------	----------	----------
Total				----------	----------	----------	----------	----------

Chart 3—Benefits

Type	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Night Differential (6 p.m. to 6 a.m.=10% additional)					
Holiday Pay (double time)					
Overtime (time and one-half)					
Lump-Sum Payments (accrued leave due at time of resignation or retirement)					
Uniform Allowance (Professional employees only—$50.00 per annum)					
Life Insurance (based on salary)					
Incentive Awards—outstanding performance—suggestion program					
Social Security					
Total					----------

SERVICE COSTS

Today many companies provide various types of skilled services. It is frequently considered advantageous to contract for these services instead of employing sufficient personnel to accomplish every task. The cost of each contract service, such as sharpening service, repairs to furniture and equipment, floor maintenance and waxing, laundry, etc., must be estimated and included as an expense. Chart 4, p. 81, is a sample work sheet for recording the projected costs of contract services.

Supplies other than subsistence

must be charged to the dietary budget. These materials include:

1. Office supplies.
2. Drugs and chemicals procured from the pharmacy.
3. Operating supplies such as detergents, brooms, mops, wax, and paper goods.
4. China, glassware and silver (new and replacements).
5. Linens (new and replacements) for such items as tablecloths, napkins, uniforms for non-professional personnel, aprons, towels, etc.
6. Small or portable equipment such as stock pots, pans, kitchen cutlery, tray conveyors, blendors, etc.
7. Fixed equipment such as ovens, steamers, mixing machines, etc. Chart 5, right, is a sample work sheet for estimating supply costs.

Chart 4—Contract services

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Sharpening Service (saws, grinder, knives and plates)					
Repairs (furniture and equipment)					
Total					

Chart 5—Supplies and equipment other than subsistence

	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Office Supplies					
Drugs, Chemicals (extracts)					
Operating Supplies (cleaning supplies, wax, etc.)					
Glassware, Silver and China (Changing pattern?)					
Linens (Qrtrs. 1 & 2 include new size tablecloths for new round tables)					
Portable Equipment					
Fixed Equipment (new and replacement)					
Total					

FOOD BUDGET

The raw food budget, which is usually of first concern to the dietitian, demands careful consideration. After the pricing of the menu and size of portions are deter-

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Chart 6—Total rations served per day, per month

No. of	Patient Rations		Employee Rations[1]						Other Rations			Total Rations	
			Full Subsistence		One Meal		Two Meals						
	In-patients	Out-patients	Table Service	Cafeteria	Table Service	Cafeteria	Table Service	Cafeteria	Guests[2]	Doctor of the Day	Entertainers	Daily	Grand Total Per Month
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													

[1]Ration equals three meals per day.
[2]Includes volunteers and affiliate students.

Chart 7—Raw food cost per quarter, per year

	Estimated No. of Rations* To Be Served Daily						Total Rations (3 meals per day)	Days in Qtr.	Rations Per Qtr.	Cost per Raw Ration	Total Raw Food Cost per Qtr.
	Doctor of the Day	Volunteers	Guests	Employees	Affiliate Students	Average Daily Patient Census					
1st Quarter	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
July-Aug.-Sept.	3	20	5	550	55	1940	2573	92	236716	.998	236,242.568
2nd Quarter											
Oct.-Nov.-Dec.	3	25	5	565	55	1960	2613	92	240396	.998	239,915.208
3rd Quarter											
Jan.-Feb.-March	3	25	5	565	55	2015	2668	90	240120	.998	239,639.760
4th Quarter											
Apr.-May-June	3	25	5	565	55	1945	2598	91	236418	.998	235,945.164
Total Per Annum									953650	.998	951,742.70

*Ration equals three meals per day.

Columns A through E averages taken from Chart 5.

Column F—estimate obtained from administrator or business manager.

Column G—sum of Columns A through F.

Column H—Actual calendar days in quarter.

Column I—Column G multiplied by H.

Column J—Taken from actual raw ration cost records. The quality of menus must be established by administrator and nutritional accounting adequate for types of patients, calculated according to current prices, current and future market.

Column K—Column I multiplied by J.

Chart 8—Budget summary

TO: Administrator

FROM: Director, Dietary Department

SUBJ: Budget Requirements for Fiscal Year 1958

Salaries and Benefits for _____ Employees $_____

Contract Services $_____

Supplies and Equipment $_____

Subsistence _____ Meals @ $_____ $_____

Total Dietary Supplies and Equipment $_____

mined, price trends in the food market and seasonal fluctuations in quality of food items should be examined and findings judiciously applied.

In this area of planning, a daily food cost accounting system is invaluable, since information on current prices or seasonal trends is as close as a card file. A review of the current year's operation plus anticipated increases or decreases in prices allows for a fairly accurate estimate that can be applied in planning the future food budget.

An actual meal count, including patients, guests, affiliate students, volunteers, and employees of all categories, is necessary in order to arrive at an accurate meal or ration cost. Chart 6, left, is a work sheet for recording this data.

The total raw food cost per quarter is obtained by multiplying the total number of meals served per day by the cost per meal by the number of calendar days in the quarter. Chart 7, left, is a suggested form for recording this information.

After these seven work sheets are completed, a summary of the data is included in the memorandum for the administrator. (See Chart 8, left).

TIME FOR BUDGET PREPARATION

The question is often asked where does the dietitian find time in her busy schedule to accomplish this task. In my opinion, the actual posting is a clerk's duty, while the administrative dietitian should concentrate on setting up the procedure and analyzing the results. The dietitian should be concerned with the fine points and techniques of budget planning and operation only insofar as is necessary to train and supervise clerical personnel and maintain controls.

VALUE OF THE BUDGET

What are the advantages of a dietary budget? It would seem there are six major dividends:

1. Definite standards of quality and quantity will be established. The dietitian will find herself analyzing every quotation to insure maximum utilization of funds without lowering quality standards.

2. Impulse buying will be curtailed.

3. Nutritional accounting based on current prices will be readily available.

4. Costs can be analyzed daily or as necessary to maintain control. Adjustments to meet budget allotments can then be made accordingly.

5. The budget will prompt the dietitian to engage in work simplification and methods improvement studies in an effort to reduce or at least keep labor costs in line.

(Continued on page 88)

Spring Cycle Menu for the South-Southwest

THE 21-DAY selective spring cycle menu and market orders for perishables are designed for hospitals in the South and Southwest. These menus, which are for use during March, April and May, feature foods popular in the South.

The menus in this issue are the second in a four-part series of spring cycle menus published in this Journal. Spring cycle menus for Midwest hospitals were included in the January 1 HOSPITALS, JOURNAL OF THE AMERICAN HOSPITAL ASSOCIATION. The spring menus for hospitals in the East and North-North-west will be published in the February 1 and 16 issues, respectively.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. A moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

In adapting items marked (S) for use on modified diets, it should be noted that certain items will need sodium or fat restriction during preparation, if they are to be served to patients on sodium or fat restrictive diets. When fruits are included on the dessert menu, the dietitian will omit sugar or substitute the water-packed variety for the diabetics.

The winter cycle menus, published in the October and November 1957 issues of this Journal, are for use during January and February. The Midwest and South-Southwest cycle menus were included in the October 1 and 16 issues, respectively. The November 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request from the Association, 18 E. Division St., Chicago 10, Ill.

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1st WEEK SOUTH-SOUTHWEST SPRING SELECTIVE CYCLE MENU—prepared by Solona C. McDonald, director of hospital dietetics, Tuskegee Institute, Ala.

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

	breakfast	noon	night
monday	Grape Juice or Sliced Oranges Buttered Grits or Puffed Rice Cereal Fried Salt Pork Cinnamon Toast	Beef Broth with Rice Steamed Big Franks or Oven Broiled Lamb Patties (FS) Mashed Potatoes (FS) and Hotbread Sautéed Sauerkraut with Apple Slices or Buttered Green Beans (FS) Carrot and Raisin Salad or Shredded Lettuce Salad Fresh Fruit Cup or Old Fashioned Sugar Cookies (FS)	Blended Vegetable Juice Chicken Livers in Gravy or Roast Beef Au Jus (FS) Steamed Rice (FS) and Hotbread Harvard Beets or Buttered Green Peas (FS) Chef's Salad—French Dressing or Cranberry Relish Salad—Cream Cheese Dressing Devil's Food Cake with White Icing (F) or Sliced Pears (S)
tuesday	Grapefruit Juice or Apple Sauce Farina or Bran Flake Cereal Soft Boiled Egg Sausage Patties	Strained Vegetable Soup Grilled Thick Sliced Bacon or Braised Beef Cubes with Potatoes (FS) Buttered Macaroni (FS) Buttered Broccoli or Buttered Carrots (FS) Tomato Aspic Salad—Mayonnaise or Pineapple-Prune Salad Frozen Sliced Strawberries or Orange Sherbet (FS)	Cream of Pea Soup Roast Pork Shoulder (FS)—Savory Cornbread Dressing (F) or Individual Meat Loafs Hotbread Scalloped Eggplant (S) or Seven-Minute Cabbage (F) Relish Plate (spring onions, radish roses, carrot sticks and olives) or Waldorf Salad Lemon Meringue Pie (F) or Sliced Peaches in Syrup (S)
wednesday	Sliced Bananas in Orange Juice or Grape Juice Whole Wheat Cereal or Corn Flakes Scrambled Eggs with Cheese	Pineapple Juice Ham Loaf—Mustard or Broiled Minute Steaks (FS) Buttered White Potatoes (FS) and Hotbread Buttered Spinach w/Sliced Egg (FS) or O'Brien Corn Fruit Salad or Sliced Tomato Salad—Mayonnaise Bread Pudding—Lemon Sauce (FS) or Fruit Gelatin	Citrus Juice—Blended Tuna Loaf (S) or Baked Spareribs (F) French Fried Sweet Potatoes and Hotbread Buttered Beets (FS) or Turnip Greens Spiced Peach Salad or Green Salad—French Dressing Apple Pie with Cheese Wedge (F) or Italian Plums in Syrup (S)
thursday	Blended Juice or Stewed Prunes Buttered Grits or Ready-to-Eat Cereal Fried Eggs Sausage Links	Chicken Broth Grilled Bologna (F) or Sautéed Beef Liver (S) Whipped Potatoes (FS) and Hotbread Buttered Carrots (FS) or French Fried Onions Tossed Vegetable Salad—French Dressing or Banana-Nut Salad—Mayonnaise Vanilla Ice Cream (FS) or Royal Anne Cherries	Tomato-Rice Soup Barbecued Beefburgers on Buns or Baked Chicken (FS)—Cornbread Dressing Buttered Peas with Tiny New Potatoes (FS) or Seasoned Mustard Greens Celery Curls, Olives and Radishes or Pears and Grated Cheese Salad—Mayonnaise Nectarines in Syrup or Baked Custard (FS)
friday	Chilled Grapefruit Half or Applesauce Puffed Rice Cereal or Oatmeal Crisp Bacon French Toast—Syrup	Chicken Soup Grilled Sausage Patties—Tiny Grilled Corn Cakes or Baked Lamb Chops (FS) Mashed Potatoes (FS) Buttered Brussels Sprouts or Buttered Green Beans (FS) Lettuce Salad with Russian Dressing or Orange-Grapefruit Salad Apricots in Syrup or Butterscotch Pudding (FS)	Beef Rice Bouillon Braised Short Ribs in Gravy or Baked Red Snapper Steaks (FS) Buttered Rice (FS) Stewed Tomatoes with Celery, Onions, and Green Peppers (F) or Buttered Chopped Spinach (S) Peach Salad—Cream Cheese Dressing or Cole Slaw Iced Cupcakes (FS) or Frozen Boysenberries
saturday	Fresh Apples or Blended Vegetable Juice Assorted Dry Cereal or Potato Cakes Link Sausage	Spiced Apple Juice Creamed Eggs on Rusk or Braised Veal Steaks (FS) Mashed Sweet Potatoes (FS) Buttered Cauliflower or Buttered Beets (FS) Pineapple Salad—Cottage Cheese Dressing or Tossed Green Salad—French Dressing Brownies (F) or Fruit Cup (S)	Tomato Juice Roast Lamb—Mint Jelly (FS) or Baked Pork Chop Stuffed Baked Potatoes (FS) and Hotbread Buttered Frozen Yellow Squash (FS) or Seasoned Mixed Greens Mixed Fruit Salad or Tomato and Lettuce Salad—1000 Island Dressing Bread Pudding (FS) or Baked Apple with Cream
sunday	Tangerines or Pineapple Juice Farina or Assorted Dry Cereal Grilled Thick Sliced Bacon	Chicken Noodle Soup Roast Veal (FS)—Spiced Apple Rings or Salad Bowl with Cheese and Ham Cubes—Mayonnaise Baked Potato (FS) and Hotbread Harvard Beets or Buttered Asparagus Tips (FS) Mixed Fruit Salad or Shredded Lettuce Salad Boston Cream Pie (FS) or Bing Cherries in Syrup	Blended Vegetable Juice Southern Fried Chicken—Cream Gravy (F) or Grilled Minute Steak and Mushrooms Au Jus (S) Steamed Rice (FS) and Hotbread Buttered Carrots (FS) or Brussels Sprouts Chef's Salad or Peach-Pear Salad Sliced Bananas in Strawberry Gelatin or Iced Sheet Cake (FS)

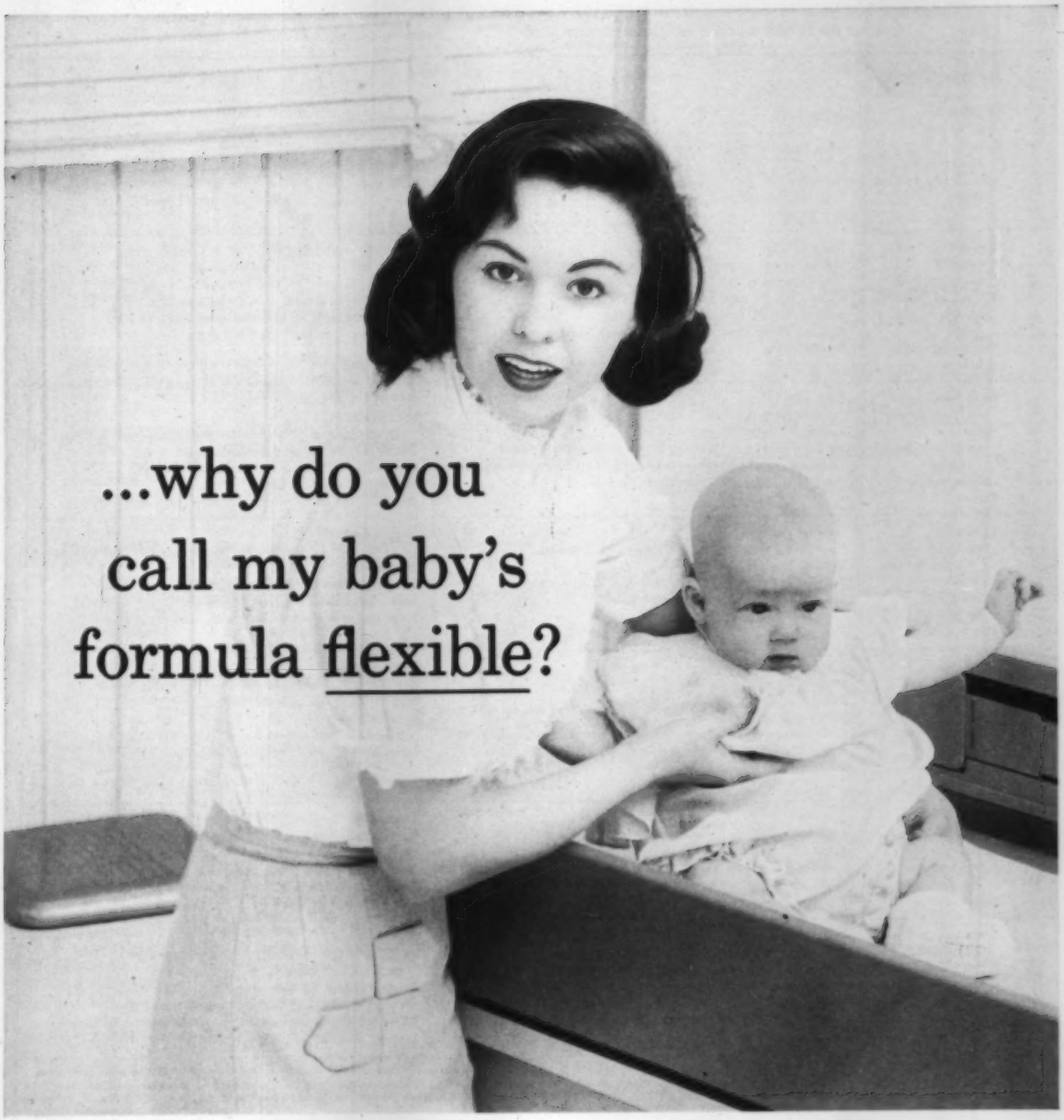
(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	20 lbs.	100
Butt, Bottom (B.R.T.)	U. S. Good	25 lbs.	75
Frankfurters	All beef, 4-1 lb.	25 lbs.	100
Ground Beef	U. S. Good, 5 lb. pkg.	12 lbs.	
Liver	Steer, sliced	5 lbs.	20
Short Ribs	U. S. Good	10 lbs.	20
Steaks, Minute	U. S. Choice, 5 oz. each	35 lbs.	105
Stew	U. S. Good	20 lbs.	100
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	35 lbs.	100
Ground, Shoulder	U. S. Good	12 lbs.	
Leg (B.R.T.)	U. S. Choice, yearling	20 lbs.	60
PORK			
Bacon (Sliced)	24-26—1 lb.	18 lbs.	216
Bacon (Sliced)	12-16—1 lb.	5 lbs.	30
Butts, Smoked (Boneless)	Lean	3 lbs.	
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Loin (Boneless)	Grade A, 10-12 lbs.	25 lbs.	75
Salt Pork		10 lbs.	
Sausage (Bulk)	Lean	10 lbs.	40
Sausage Links	12—1 lb.	15 lbs.	60
Spareribs	Grade A, 3 lb. average	25 lbs.	50
VEAL			
Leg (B.R.T.)	U. S. Good	35 lbs.	105
Steaks, Club	U. S. Good, 5 oz. each	35 lbs.	100
FISH			
Red Snapper	Fillets	15 lbs.	60
POULTRY			
Fryers (Eviscerated)	Grade A, 2½ lb. av.	70 lbs.	135
Livers, Chicken	1 lb. pkg.	2 lbs.	10
FRESH FRUITS			
Apples	Jonathon, 113s	2 boxes	
Bananas	Ripe	60 lbs.	
Grapefruit	Seedless, 70s	1 case	
Grapes	Emperor	30 lbs.	
Lemons		1 doz.	
Oranges	176s	1 box	
Tangerines	Crate, 144s	1 crate	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	100 lbs.	
Celery	Pascal, 30s	1 crate	
Chicory	Bunch	5 bunches	
Cucumbers		1 doz.	
Eggplant		2 only	
Lettuce	Head, 48s	2 boxes	
Onions, Dry	Yellow, bag	50 lb. bag	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	200 lbs.	
Radishes	Bunch	1 doz.	
Tomatoes	Repacked (5 x 6)	60 lbs.	
FROZEN FRUITS			
Orange Juice	Con., 32 oz. can	6 cans	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	2 cans	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Cuts, 2½ lb. pkg.	45 lbs.	270
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	5 lbs.	30
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Greens, Mustard	2½ lb. package	2½ lbs.	15
Peas	2½ lb. pkg.	15 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	17½ lbs.	105
Squash, Winter	3 lb. pkg.	15 lbs.	90
Turnip Greens	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL



In contrast to proprietary formulas, which can only be made weaker or stronger, the evaporated milk formula is *flexible* because it can be:

– adjusted in dilution and *carbohydrate content* to meet neonatal needs without renal overload.

– gradually increased in concentration and the carbohydrate *specified by the physician* as the baby grows.

– adjusted in concentration, nutritional balance, or both, in any period of stress, such as illness.

– decreased in carbohydrate in direct ratio with the infant's increasing ability to assimilate solid foods.

– used in place of fresh milk at normal milk dilution during weaning from bottle to cup.

Carnation
"FROM CONTENTED COWS"

Optimum prescription-quality in today's trend to the individualized formula.

2nd WEEK SOUTH-SOUTHWEST SPRING SELECTIVE CYCLE MENU—prepared by Solona C. McDonald, director of hospital dietetics, Tuskegee Institute, Ala.

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

	breakfast	noon	night
monday	Grapefruit Juice **or** Bananas Farina **or** Corn Flakes Scrambled Eggs with Cheese	Chicken Broth Roast Shoulder of Lamb (FS) **or** Creamed Chipped Beef Baked Mashed Potatoes (FS) **and** Hotbread Buttered Okra **or** Candied Carrot Pennies (FS) Fruit Salad Bowl with Cottage Cheese **or** Tossed Green Salad—French Dressing Fruit Bar **or** Vanilla Ice Cream (FS)	Pineapple Juice Grilled Cubed Steaks (FS) **or** Glazed Ham Baked Sweet Potatoes (FS) **and** Hotbread Buttered Mixed Vegetables **or** Seasoned Mustard Greens (FS) Green Onions, Radishes and Pickles **or** Spiced Crabapple on Lettuce Peach Shortcake (F) **or** Gelatin with Custard Sauce (S)
tuesday	Stewed Dried Fruit Compote **or** Tomato Juice Oatmeal **or** Ready-to-Eat Wheat Flake Cereal Poached Egg—Link Sausage	Vegetable Soup Sautéed Smoked Sausage with Fried Apples **or** Casserole of Veal Cubes (FS) Buttered Rice (FS) **and** Hotbread Buttered Peas (FS) **or** French Fried Eggplant Banana-Pecan Salad **or** Health Salad—French Dressing Royal Anne Cherries (S) **or** Oatmeal Cookies (F)	Cream of Tomato Soup Corned Beef Brisket (F) **or** Roast Pork (S) Beef Stock Potatoes (FS) **and** Hotbread Seven-Minute Cabbage (F) **or** Buttered Asparagus Tips (S) Stuffed Prune Salad **or** Marinated Mixed Vegetable Salad Pear Halves (S) **or** Chocolate Meringue Pie (F
wednesday	Prune Juice **or** Fresh Grapes Farina **or** Assorted Dry Cereal Link Sausage Biscuits	Onion Soup Italian Spaghetti with Meat Sauce (F) **or** Baked Salmon Croquettes (S) Escalloped Potatoes (FS) **and** Hotbread Buttered Spinach with Sliced Egg (FS) **or** Buttered Green Lima Beans Cabbage, Carrot, Green Pepper Salad **or** Apple Ring Salad with Mayonnaise Sweet Potato Cake with Caramel Icing **or** Baked Pear (S)	Clear Vegetable Soup Roast Beef—Gravy (FS) **or** Cold Sardines on Lettuce with Sliced Lemons and Sliced Eggs Mashed Potatoes (FS) **and** Hotbread Seasoned Green Beans (FS) **or** Baked Acorn Squash Tomato Aspic **or** Chef's Salad Fresh Fruit Cup **or** Butterscotch Pudding—Whipped Topping (FS)
thursday	Apple Juice **or** Orange and Grapefruit Sections Buttered Grits **or** Wheat Cereal Thin Sliced Grilled Ham	Cream of Pea Soup Macaroni and Cheese (S) **or** Cold Meat Platter—Mustard (F) Macaroni Salad (F) **and** Hard Roll Buttered Wax Beans (FS) **or** Seasoned Okra Carrot Sticks, Celery Curls and Radish Roses **or** Blush Pear Salad with Lorenzo Dressing Coconut Cream Pie (F) **or** Stewed Fruit Compote (S)	Blended Vegetable Juice Baked Chicken—Dressing—Gravy (FS) **or** Corn Beef Hash with Potatoes Hotbread Buttered Julienne Carrots (FS) **or** Buttered Brussels Sprouts Lettuce Salad with Garlic French Dressing **or** Mixed Fruit Salad Fudge Cake with White Mountain Icing (F) **or** Baked Apples (S)
friday	Orange Juice **or** Applesauce Oatmeal **or** Ready-to-Eat Wheat Flake Cereal Grilled Sausage Patties Coffeecake	Tomato Soup Oven Broiled Ground Round Steak (FS) **or** Fish Sticks Parsley Buttered Potatoes (FS) **and** Hotbread Seasoned Mustard Greens **or** Buttered Beets (FS) Chef's Salad with French Dressing **or** Peach, Pear, Maraschino Cherry Salad Orange Sherbet (FS) **or** Date-Fig Bars	Grapefruit Juice Oven-Baked Pork Cutlets **or** Sea Bass Steaks—Tartar Sauce (FS) Hush Puppies (F) **or** Au Gratin Potatoes (S) Buttered Spinach (FS) **or** Stewed Tomatoes with Onions, Celery and Green Peppers Lemon Meringue Pie (F) **or** Sliced Peaches (S)
saturday	Blended Vegetable Juice **or** Stewed Prunes Buttered Grits **or** Bran Flake Cereal Ham Omelet	Onion Soup Roast Turkey—Gravy (FS) **or** Grilled Thick Sliced Bacon Baked Grits Seasoned String Beans (FS) **or** Buttered Mixed Vegetables Cranberry Jelly on Lettuce **or** Head Lettuce Salad with Russian Dressing Ambrosia (F) **or** Creamy Rice Pudding	Turkey Soup Salisbury Steak—Gravy (S) **or** Grilled Ham (F) Baked Corn (F) **and** Hotbread Buttered Peas (FS) **or** Turnip Greens with Seasoning Tomato Lettuce Salad—Mayonnaise **or** Jellied Fruit Salad Cherry Crisp **or** Ice Cream (FS)
sunday	Grape Juice **or** Chilled Grapefruit Half Buttered Grits **or** Bran Cereal Poached Eggs Salt Pork in Batter, Fried	Apple Juice Grilled Shoulder Lamb Chops (FS) **or** Cold Meat Platter—Potato Chips Paprika Potatoes (S) **and** Hotbread Baked Acorn Squash (FS) **or** Buttered Peas and Carrots Kidney Bean Salad **or** Radishes, Carrot Curls, Pepper Rings—Mixed Sweet Pickles Pumpkin Cake (F) **or** Pears in Syrup (S)	Fruit Punch Roast Leg of Veal—Gravy (FS)—Savory Dressing (F) **or** Baked Pork Chops—Gravy Mashed Potatoes (FS) **and** Hotbread Seasoned Rutabagas **or** Buttered Chopped Spinach (FS) Tossed Green Salad—French Dressing **or** Cranberry Jelly Salad Canned Peaches (S) **or** Strawberry Shortcake (F)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	15 lbs.	
Brisket, Corned	U. S. Good	40 lbs.	
Butt, Bottom (B.R.T.)	U. S. Good	60 lbs.	
Chipped Beef, Dried	U. S. Good	2 lbs.	20
Ground Beef	U. S. Commercial, 5 lb. pkg.	45 lbs.	
Steaks, Cubed	U. S. Choice, 4 oz. each	20 lbs.	80
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	30 lbs.	90
Leg (B.R.T.)	U. S. Choice, yearling	30 lbs.	90
PORK			
Bacon (Sliced)	10-12—1 lb.	5 lbs.	
Chops, Loin	Grade A, 4 oz. each	5 lbs.	20
Cutlets	Grade A, 4 oz. each	5 lbs.	20
Ham (Pullman)	Ready-to-eat	20 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	10 lbs.	
Salt Pork		5 lbs.	50
Sausage (Bulk)	Lean	10 lbs.	40
Sausage Links	12—1 lb.	20 lbs.	80
Sausage, Smoked	8—1 lb.	5 lbs.	20
VEAL			
Leg (B.R.T.)	U. S. Good	30 lbs.	90
Stew	U. S. Good	20 lbs.	80

Item, Specifications, Amounts & No. of Servings			
FISH			
Bass, Sea	Fillets	20 lbs.	80
Sticks, Fish		5 lbs.	20
POULTRY			
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	60 lbs.	100
Fryers (Eviscerated)	Grade A, 2½ lb. av.	50 lbs.	80
FRESH FRUITS			
Apples	Jonathon, 113s	2 boxes	
Bananas	Ripe	60 lbs.	
Grapefruit	Seedless, 70s	1 box	
Grapes	Emperor	28 lbs.	
Lemons		1 doz.	
Oranges	176s	1 box	
Pears	Box, 120s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	100 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 crate	
Cucumbers		1 doz.	
Eggplant		3 only	
Lettuce	Head, 48s	2 crates	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	

Item, Specifications, Amounts & No. of Servings			
Peppers, Green		6 only	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1 doz.	
Rutabagas		5 lbs.	
Squash, Acorn		20 lbs.	
Tomatoes	Repacked (5 x 6)	30 lbs.	
FROZEN FRUITS			
Cherries	8 lb. can, 5-1 sugar	8 lbs.	
Peaches	Sliced, 8 lb. can, 5-1 sugar	8 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	2½ lbs.	15
Beans, Green	Cuts, 2½ lb. pkg.	15 lbs.	90
Beans, Green	Julienne, 2½ lb. pkg.	15 lbs.	90
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Beans, Wax	Cuts, 2½ lb. pkg.	15 lbs.	90
Greens, Mustard	2½ lb. pkg.	17½ lbs.	105
Greens, Turnip	2½ lb. pkg.	2½ lbs.	15
Okra	2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	35 lbs.	195
Spinach	Chopped, 2½ lb. pkg.	45 lbs.	270
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

CYCLE MENU PAGES ARE PERFORATED FOR EASY REMOVAL

3rd WEEK SOUTH-SOUTHWEST SPRING SELECTIVE CYCLE MENU—prepared by Solona C. McDonald, director of hospital dietetics, Tuskegee Institute, Ala.

(MENUS TO BE USED DURING MARCH, APRIL AND MAY)

	breakfast	noon	night
monday	Orange and Grapefruit Sections **or** Prune Juice Assorted Dry Cereal **or** Oatmeal Fried Salt Pork Dipped in Batter	Strained Vegetable Soup Meat Loaf—Mushroom Gravy (FS) **or** Grilled Ham Steaks Parsley Buttered Potatoes (FS) **and** Hotbread Minted Carrots (FS) **or** Buttered Asparagus Tips (S) Waldorf Salad **or** Shredded Lettuce Salad—French Dressing Creamy Rice Pudding (FS) **or** Purple Plums	Turkey Soup Broiled Veal Rosettes **or** Roast Beef—Gravy (FS) Mashed Potatoes (FS) **and** Hotbread Buttered Spinach with Egg (FS) **or** Okra and Tomatoes Chef's Salad with Garlic Dressing **or** Fruit Salad with Fruit French Dressing Apple Pie with Cheese (F) **or** Ice Cream (S)
tuesday	Blended Juice **or** Kadota Figs Buttered Grits **or** Puffed Wheat Cereal Fish Cakes	Tomato Soup Grilled Bologna and Scrambled Eggs (F) **or** Open Faced Turkey Sandwich (S) Baked Potatoes (FS) Orange Beets (FS) **or** Baked Dried Lima Beans Pineapple Salad **or** Tossed Green Salad—Chiffonade Dressing Banana Cream Pie (F) **or** Chilled Pear Halves (S)	Cream of Pea Soup Broiled Lamb Patties (S) **or** Roast Pork Loin (F) Baked Sweet Potatoes with Marshmallows (FS) Frozen Green Black-eyed Peas **or** Seasoned Fresh Mustard Greens (FS) Green Onions, Radishes, Pickles **or** Stuffed Prune Salad Mixed Fruit Compote (S) **or** Spiced Cake with White Icing (F)
wednesday	Frozen Peaches **or** Grapefruit Juice Farina **or** Corn Flakes Poached Eggs—Crisp Bacon	Beef Broth with Noodles Braised Lamb Cubes—Mint Jelly (S) **or** Mexican Chilli Con Carne (F) Steamed Rice (FS) **and** Biscuits Buttered Carrots and Peas **or** Baked Acorn Squash (FS) Shredded Cabbage-Radish Salad **or** Jellied Fruit Salad Apricots in Syrup **or** Sheet Cake with Caramel Icing (FS)	Blended Vegetable Juice Baked Veal Chops (S) **or** French Fried Fish Sticks—Hush Puppies (F) Creamed Potatoes (FS) Stewed Tomatoes (F) **or** Buttered Asparagus Tips (S) Cinnamon Apples on Lettuce **or** Tossed Green Salad—French Dressing Lemon Sherbet (FS) **or** Fruit Cup
thursday	Apple Juice **or** Bananas Grits **or** Corn Flakes Eggs to Order	Grapefruit Juice Broiled Chicken (FS) **or** Grilled Franks and Boston Baked Beans Buttered Potatoes (FS) **and** Hotbread Buttered Green Beans (FS) **or** Mashed Squash Tossed Green Salad **or** Peach Salad with Cherry Garnish Plain Ice Box Cookies (S) **or** Ambrosia (F)	Vegetable Soup Baked Pork Cutlets (F) **or** Sautéed Beef Liver (S) Au Gratin Potatoes (FS) **and** Hotbread Seasoned Mustard Greens (FS) **or** French Fried Onions Sliced Cucumber-Tomato Salad—Vinegrette Dressing **or** Jellied Pear Salad Nectarines in Syrup **or** Peach Betty (FS)
friday	Sliced Oranges **or** Grape Juice Farina **or** Assorted Dry Cereal Potato Cakes—Thin Sliced Grilled Ham	Pineapple Juice Veal Chop Suey (F) **or** Baked Salmon Croquettes with Cream Pea Sauce (S) Escalloped Potatoes (FS) Stewed Tomatoes (F) **or** Buttered Green Peas (S) Stuffed Celery **or** Melon Ball Salad Applesauce Cake with Powdered Sugar (F) **or** Lime Sherbet (S)	Tomato Soup Baked Round Steak with Gravy (FS) **or** French Fried Shrimps Whipped Potatoes (FS) Buttered Julienne String Beans (FS) **or** Cauliflower—Cheese Sauce Sliced Orange-Grapefruit Salad **or** Marinated Mixed Vegetable Salad Lemon Chiffon Pie (F) **or** Baked Apple (S)
saturday	Fresh Apples **or** Blended Fruit Juice Oatmeal **or** Bran Cereal Hot Cakes—Syrup Bacon	Vegetable Bouillon Stewed Chicken with Noodles (FS) **or** Cheeseburgers on Buns Buttered Mixed Vegetables **or** Buttered Spinach—Sliced Lemon (FS) Cole Slaw **or** Pineapple, Pear and Peach Salad Chocolate Sundae (FS) **or** Frozen Fresh Raspberries	Cream of Mushroom Soup Broiled Veal Patties **or** Grilled Pork Chops—Applesauce (F) Boiled Pinto Beans (F) Turnip Greens with Seasoning **or** Buttered Beets (FS) Green Onions, Cucumber Ring, Radish Roses, Carrot Sticks, and Sweet Pickles **or** Tomato Aspic Salad Pineapple Upside-down Cake (F) **or** Fruit Cup (S)
sunday	Orange Juice **or** Stewed Prunes Grits **or** Assorted Dry Cereal Grilled Canadian Bacon Blueberry Muffins	Chicken Soup Broiled Lamb Shoulder Chops (FS) **or** Individual Meat Loafs—Gravy Oven-Browned Potatoes **and** Biscuits Buttered Julienne Carrots (FS) **or** Buttered Lima Beans Marinated Vegetable Salad **or** Minted Fruit Salad Devil's Food Cake with Mocha Icing (F) **or** Lemon Sherbet (S)	Cranberry Juice Veal Chop Suey **or** Broiled Minute Steak (FS) Buttered Rice (FS) **and** Hotbread Buttered Asparagus (FS) **or** Brussels Sprouts in Cheese Sauce Chef's Salad **or** Carrot Raisin Salad Canned Fruit Compote (S) **or** Pecan Pie (F)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Bologna	All beef	20 lbs.	100
Butt, Bottom (B.R.T.)	U. S. Good	20 lbs.	60
Frankfurters	All beef, 8-1 lb.	5 lbs.	20
Ground Beef	U. S. Good, 5 lb. pkg.	45 lbs.	
Liver	Steer, sliced	5 lbs.	20
Steaks, Cubed	U. S. Choice, 4 oz. each	15 lbs.	60
Steaks, Sirloin Butt	U. S. Choice, 5 oz. each	20 lbs.	60
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	35 lbs.	105
Ground, Shoulder	U. S. Good	5 lbs.	20
Stew	U. S. Good	5 lbs.	20
PORK			
Bacon, Canadian		4 lbs.	40
Bacon (Sliced)	24-26—1 lb.	12 lbs.	144
Chops, Loin	Grade A, 4 oz. each	15 lbs.	60
Cutlets	Grade A, 4—1 lb.	15 lbs.	60
Ham (Pullman)	Ready-to-eat	30 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	20 lbs.	60
Salt Pork		5 lbs.	40
VEAL			
Shoulder (Boneless)	U. S. Good	5 lbs.	20
Stew	U. S. Good	25 lbs.	100

Item, Specifications, Amounts & No. of Servings			
FISH			
Shrimp	26-28—1 lb.	3 lbs.	24
Sticks, Fish		5 lbs.	20
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	75 lbs.	100
Fryers (Eviscerated)	Grade A, 2½ lb. av.	65 lbs.	100
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Bananas	Ripe	40 lbs.	
Grapefruit	Seedless, 70s	1 box	
Lemons		1 doz.	
Oranges	176s	1 box	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	100 lbs.	
Celery	Pascal, 30s	2 crates	
Cucumbers		1 doz.	
Lettuce	Head, 48s	3 boxes	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	1 doz.	
Parsley	Bunch	1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	300 lbs.	
Radishes	Bunch	1 doz.	

Item, Specifications, Amounts & No. of Servings			
Squash, Acorn		30 lbs.	
Tomatoes	Repacked (5 x 6)	60 lbs. (2 lugs)	
FROZEN FRUITS			
Apples	8 lb. can	16 lbs.	
Melon Balls	8 lb. can	1 can	
Orange Juice	Con., 32 oz. can	6 cans	
Peaches	Sliced, 8 lb. can, 5-1 sugar	2 cans	
Raspberries, Red	8 lb. can, 5-1 sugar	1 can	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	17½ lbs.	105
Beans, Green	Cuts, 2½ lb. pkg.	17½ lbs.	105
Beans, Green	Julienne, 2½ lb. pkg.	10 lbs.	60
Beans, Lima	Small, green, 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Greens, Mustard	2½ lb. pkg.	20 lbs.	120
Peas	2½ lb. pkg.	2½ lbs.	15
Peas, Blackeyed	2½ lb. pkg.	2½ lbs.	15
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	160
Squash, Winter	3 lb. pkg.	3 lbs.	15
Turnip Greens	2½ lb. pkg.	2½ lbs.	15
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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book reviews

measuring ability to pay

also:
medical records survey

HOW TO MEASURE ABILITY TO PAY SOCIAL AND HEALTH SERVICES. Community Council of Greater New York. New York, the Council, 1957 46 pp. $1.

Those few hospitals that label as "free work" those accounts receivable that remain after dunning letters and collection agencies have failed to extract full charges from empty pocketbooks can save a dollar by refraining from purchasing this booklet. But if the hospital is one of the majority that conducts its admitting office and business office functions with a social conscience, obtaining a copy of this booklet will prove a wise and profitable investment.

As hospital operating costs go up, and charges to patients necessarily increase commensurately, partial payments of full charges will become an increasingly important source of hospital income. To determine what portion of full charges a patient can and should pay is now a problem and will become progressively more of a problem—from both qualitative and quantitative aspects. The appended tables are convenient tools to help solve those problems. Of value, too, are the suggested work sheet forms to be used by the patient's interviewer.

For those hospitals that are located where living costs might be significantly different from those in metropolitan New York, it will be necessary to obtain also a copy of *A Family Budget Standard for the Use of Social and Health Agencies in New York City*, another publication of the Community Council of Greater New York, and to adjust certain of the tables in *How to Measure Ability to Pay* . . . in accordance with the difference between local and New York City's basic costs of living (as defined in the *Family Budget Standard.*)

Nonetheless, although they are the culmination of the discussion presented, the tables are not the only things of value in this booklet. The discussion itself is a veritable textbook of ideas and information from which hospital admitting and credit personnel can learn a lot about determining a patient's ability to pay.

The project of preparing the booklet was first inaugurated by New York's Community Council to establish a basis for increasing the uniformity of the partial fee-charging policies and practices of the various social service agencies in the city. Many hospital administrators, as they review the booklet, will wonder why their city or area hospital councils have not yet developed the same idea of promoting more uniform partial fee-charging practices. The booklet may prompt action in this area—action beneficial to hospitals and to the public they serve.—RICHARD J. ACKART, M.D., *executive director, Virginia Hospital Service Association, Richmond, Va.*

Medical records survey

THE FUNCTIONS AND EDUCATION OF MEDICAL RECORD PERSONNEL. Antonio Ciocco and others. Pittsburgh, University of Pittsburgh Press, 1957. 78 pp. $2.

This is an excellent survey of the functions of medical record personnel, especially the medical record librarian. The functions are surveyed from the viewpoint of active medical record librarians in various hospitals which differ in size and type, and from the viewpoints of hospital administrators, physicians and hospital department heads. There is a tabular summary of the functions of medical records, as well as the medical record technician, with reference to: (1) assisting the medical staff; (2) development, analysis, and technical evaluation of clinical records; (3) development of secondary records; (4) development of statistics; (5) organization of departmental records; (6) preservation of records; (7) education, information and training; (8) management of medical record department. This part of the survey also points out the value of medical record technicians in saving time from routine for medical record librarians.

The second part of the survey reports on the present methods of educating medical record personnel and, without too much criticism of present methods, develops what appears to be a fine curriculum for students of medical record library science to receive a baccalaureate degree in the field. The questions of postgraduate education in the field and/or internship is purposely left out of this survey.

The excellent index adds to the value of this book as a reference tool for the hospital administrator and the medical record librarian. It could also be used by the record committee to educate physicians concerning the optimum use to which medical records can be put. —JOHN L. WILSON, *medical director, medical officer in charge, U. S. Public Health Service Hospital, New Orleans.*

Budget planning in the dietary service of a large hospital

(Continued from page 82)

6. The budget will provide the dietitian and administrator with accurate data concerning dietary operation. This data will help the dietitian reduce expenses to the lowest practicable level, consistent with proper operation, by indicating possible economies and controls.

The results achieved through the operation of a well organized financial plan are extremely rewarding to the dietitian in charge. The budget planned in a manner that will ensure the standards of quality and quantity of food and service desired by management earns respect from the hospital staff and promotes patient satisfaction. ■

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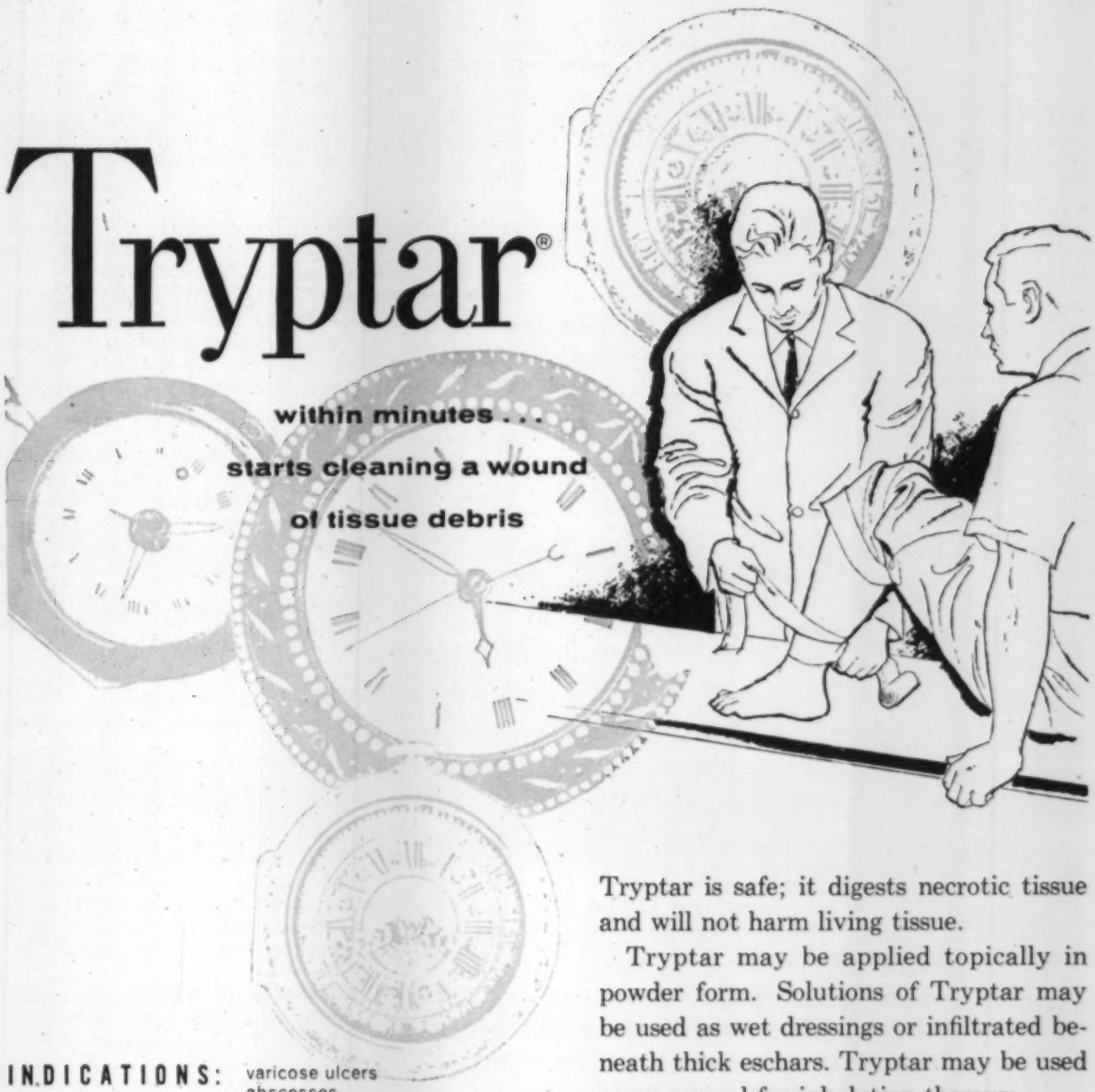

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personnel changes

● **Roderick A. Gettel** has been appointed assistant administrator of Grant Hospital, Columbus, Ohio. He was recently discharged from the Air Force. Mr. Gettel is a graduate of the Northwestern University program in hospital administration.

● **Florence Gregoric** has been appointed coordinator of admissions at Alexandria (Va.) Hospital. Miss Gregoric was formerly administrative assistant and chief dietitian at Malden (Mass.) Hospital.

● **John M. Jenkins** has been appointed assistant superintendent of Chicago State Hospital. He was formerly assistant superintendent of Alton (Ill.) State Hospital and superintendent of Beyer Hospital, Ypsilanti, Mich.

● **James E. Jenkins** has been appointed administrator of Southampton (N.Y.) Hospital. He succeeds C. G. Hutchinson, USA, ret. Mr. Jenkins was formerly administrator of Bernalillo County Indian Hospital, Albuquerque, N. Mex. He is a graduate of the Columbia University course in hospital administration.

● **Harold L. Jones** has been appointed administrator of Missouri Delta Community Hospital, Sikeston, Mo. Mr. Jones was formerly an elementary school principal.

● **Henry A. Kallio** has been appointed administrator of Lompoc (Calif.) Hospital. He succeeds **Patricia Wandler, R.N.,** who resumes her position as director of nurses at the hospital. Mr. Kallio was formerly administrator of St. John's Lutheran Hospital, Libby, Mont.

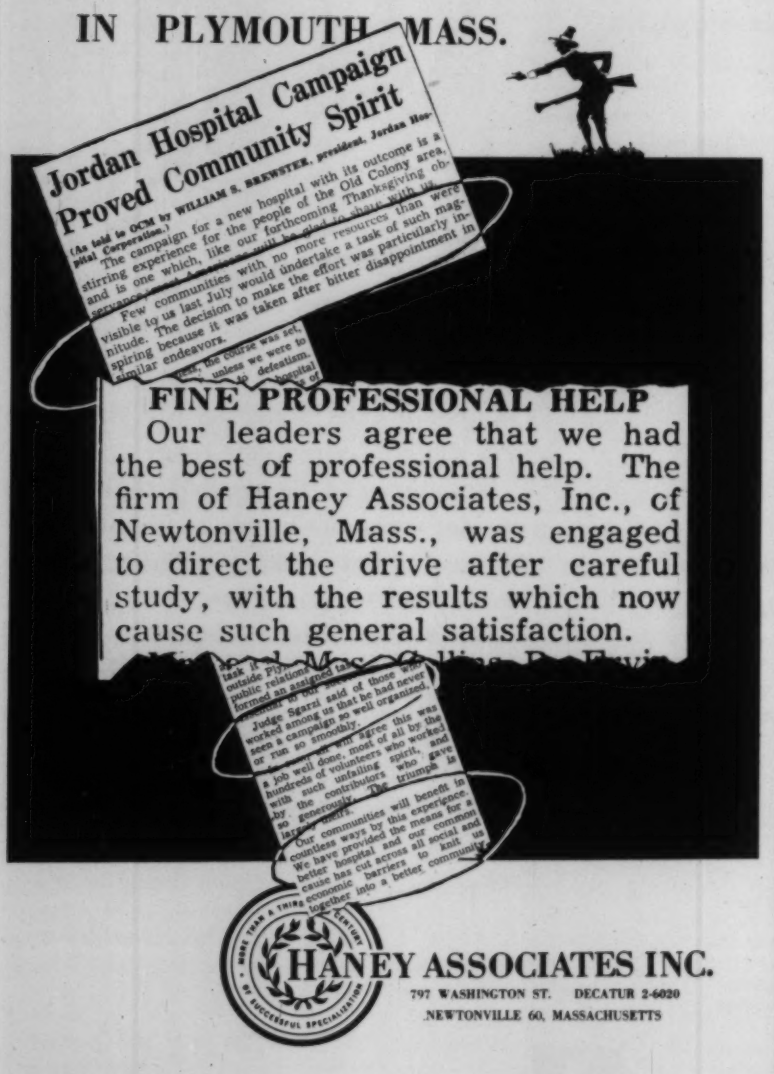
● **Wilfred H. Kelley** has been appointed executive director of Blythedale Hospital, Valhalla, N.Y. He succeeds **Jacob Reingold.** Mr. Kelley was formerly assistant director of Newark (N.J.) Beth Israel Hospital.

● **K. Kistner** has been appointed administrator of Jersey Community Hospital, Jerseyville, Ill. Mr. Kistner was formerly administrator of Miners Hospital, Christopher, Ill.

● **Talmage H. Lewis** has been appointed director of hospital administration, Department of Mental Health, state of Kentucky, Louisville. Mr. Lewis was formerly administrator of Olathe (Kans.) Community Hospital. He is a graduate of the Washington University program in hospital administration. **Mack Herron** succeeded Mr. Lewis at Olathe. Mr. Herron was formerly an internal auditor at Kaiser Hospital Foundation, Oakland, Calif.

● **Larry C. Lomax** has been appointed administrator of Sierra Madre (Calif.) Hospital. He was formerly business administrator of Sierra Madre Medical Center.

● **Edgars M. Maculans, M.D.,** has been appointed superintendent of Henryton (Md.) State Hospital. He was formerly chief physician at the hospital. Dr. Maculans suc-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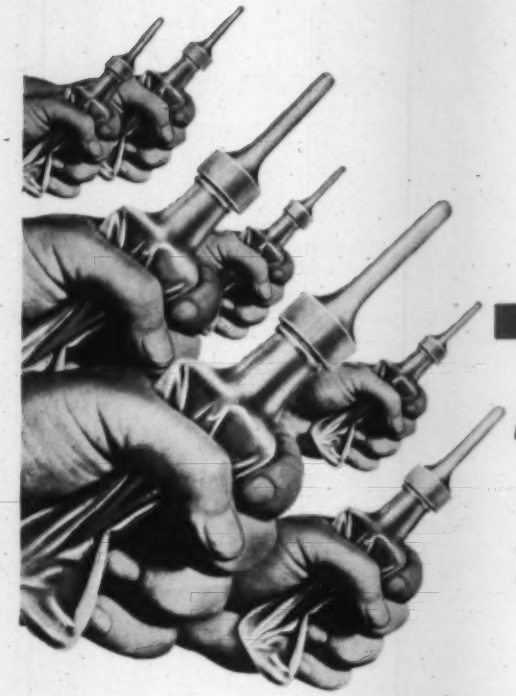

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1. "Standard vs Disposable Unit Enema": Rainier, W. G.: and Lee, B., Hospitals 31:50, Jan. 1, 1957
2. Swinton, N. W., Surg. Clinics No. Am. 35:833, 1955
3. Palmer, E. D., "Clinical Enterology," Hoeber-Harper, 1957

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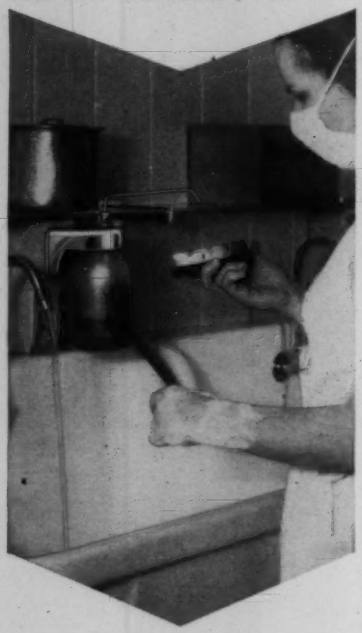

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ceeds **Tom F. Vestal, M.D.,** who has been appointed superintendent of Victor Cullen State Hospital, Cullen, Md.

● **Mother M. Patrice** has been appointed administrator of St. Joseph's Hospital, Alliance, Nebr., succeeding **Mother M. Celsa,** now on the nursing staff of St. Anthony Hospital, O'Neill, Nebr.

● **Mother M. Patricia, O.S.F.,** has been appointed administrator of Sacred Heart Hospital, Havre, Mont. She was formerly director of nursing service at St. Francis Hospital, Lynwood, Calif.

● **Carl G. Murphy** has been appointed administrator of Sarah D. Culbertson Memorial Hospital, Rushville, Ill. For 10 years Mr. Murphy was in the administrative field in Baton Rouge, La.

● **Sydney C. Palmer** has been appointed associate director of Sinai Hospital, Detroit. He was formerly assistant director of Brooklyn (N.Y.) Jewish Hospital.

● **Richard E. Sawyer** has been appointed administrator of the American University Hospital, Beirut, Lebanon, and assistant professor in hospital administration in the School of Public Health at the American University of Beirut. Mr. Sawyer was formerly assistant administrator at the hospital and instructor in the school. He is a graduate of the Columbia University program in hospital administration.

● **Florence I. Sharpe, R.N.,** has been appointed administrator of Henrietta D. Goodall Hospital, Sanford, Maine. She was formerly superintendent of Maine Eye and Ear Infirmary, Portland.

● **Sister M. Amelia, O.S.F.,** has been appointed administrator of St. Anthony's Hospital, Terre Haute, Ind. She was formerly administrator of St. Elizabeth Hospital, Lafayette, Ind.

● **Sister Mary Bonaventure, R.S.M., R.N.,** has been appointed administrator of Our Lady of Mercy Hospital, Morganfield, Ky. She was formerly supervisor of the laboratory and x-ray department at St. Rita's Hospital, Lima, Ohio.

● **Sister M. Immaculata, R.S.M., R.N.,** has been appointed administrator of St. Joseph Mercy Hospital, Centerville, Iowa. She succeeds **Sister M. Patrice, R.S.M.**

● **Sister M. Laurentia, C.S.J.,** has been appointed administrator of Mt. Carmel Hospital, Pittsburg, Kans. She was formerly administrator of Halstead (Kans.) Hospital.

● **Sister M. Loretta, O.S.F.,** has been appointed superior of the Sacred Heart Hospital, Garrett, Ind., succeeding **Sister M. Daniel** who has been transferred to St. Joseph Hospital, Elgin, Ill. Sister Loretta was formerly admitting office manager at St. Charles Hospital, Aurora, Ill.

● **Sister Eugene Marie, S.S.M.,** has been appointed administrator of St. Mary's Hospital, Jefferson City, Mo. She was formerly assistant administrator of St. Mary's Infirmary, St. Louis, and director of the infirmary's School of Nursing.

● **Sister Helen Marie** has been appointed administrator of St. Margaret's Hospital, Spring Valley, Ill. She was formerly administrator of St. Andrew's Hospital, Bottineau, N. Dak.

● **Sister Mary Vincent,** administrator of St. Joseph's Hospital, Fort Worth, Tex., has been appointed inspectress of hospitals for the congregation of the Sisters of Charity of the Incarnate Word. She will continue with her administrative duties at the hospital.

● **Sister Miriam Vincent** has been appointed administrator of St. Vincent's Hospital of Westchester County, Harrison, N.Y. She succeeds **Sister Marie LeGras.** Sister Miriam Vincent was formerly assistant administrator of St. Vincent's Hospital of New York City.

● **Sister M. Virgilia, O.S.F.,** has been appointed administrator of St. Francis Hospital, Cape Girardeau, Mo. She was formerly nursing supervisor at St. Joseph's Hospital, Milwaukee.

● **Lucille Smith** has been appointed acting administrator of Juab County Hospital, Nephi, Utah.

● **Willard A. Smith** has been appointed administrator of Bank Street Hospital, Decatur, Ala. He was formerly business manager of the hospital.

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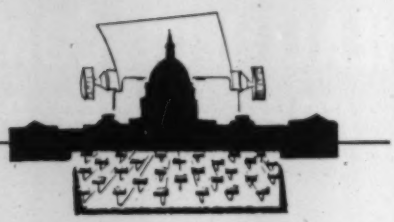
WASHINGTON REPORT



President's Budget Awaited

Congress reconvened Jan. 7 and awaited President Eisenhower's word on which way the country will move in what is being called a "crisis of confidence." The President's State of the Union message was set for Jan. 9. His budget must go to Congress before Jan. 22.

How the national health and hospital programs will shape up can only be speculated upon, but some general observations are possible.

In an election year increasing pressures will set Republicans and Democrats vying with one another to top administration requests for politically safe appropriations in support of missile programs, national defense, and scientific education.

Congressional energy and attention will focus on the 1958 elections and the economic dilemma of balancing

PRES. EISENHOWER

REP. WILLIAMS

REP. MILLS

a federal budget in the face of Soviet military and scientific achievements. Much less attention will be given to health and hospital projects.

Indicative of the congressional temper is an excerpt from a statement by Rep. John Bell Williams (D-Miss.): "It is my personal opinion that in view of the large number of new public health programs authorized by the 84th Congress which impose additional responsibilities on the Public Health Service, it may be advisable at the present time to put up a 'go slow' sign with respect to any additional such programs."

Rep. Williams succeeded the late Rep. Percy Priest as chairman of the Subcommittee on Health and Science Legislation which passes on such vital projects as Hill-Burton, medical school construction, and federal health insurance subsidies.

Another new and important congressional personality in the House, whose voice will carry weight on health legislation, is Rep. Wilbur Mills (D-Ark.), slated to become chairman of the House Ways and Means Committee, succeeding Rep. Jere Cooper (D-Tenn.), who died on Dec. 18.

Pending before this powerful House committee is the Forand bill (H.R. 9467) which would provide hospital and surgical care for the aged through the social security system's framework.

Rep. Mills is an authority on social security and taxation. His most recent active role was as chairman of the fiscal policy subcommittee of the Congressional Joint Economic Committee which held extensive hearings on complex problems of federal spending affecting America's economic structure.

With unemployment becoming a national issue, it will be Rep. Mills' views that will be sought in the House on federal programs to meet the threat of a recession.

Department of Health, Education, and Welfare Secretary Marion B. Folsom has already told Rep. Mills about his department's approach to capital outlay for health and education in the event of a depression. The secretary's views are set forth in a paper given to Mills' committee.

Hospitals are included among those projects the federal government would undertake in a public works program. Sec. Folsom wrote, in part, that "according to information and estimates developed by state and local authorities, the backlogs of needs for public school construction, water pollution control, hospitals and medical facilities total approximately $22 billion. It is clear, therefore, that if it were necessary for the nation to undertake an emergency expansion of public works there would be no occasion for 'make work' projects. The backlog of equipment, needs for new buildings and the re-equipment of existing buildings cannot be estimated with any degree of precision but is believed to be very substantial."

Approximately a year ago the American Hospital Association documented hospital building and equipment needs in a special survey on modernization and renovation of existing hospital facilities.

In the event of a recession these statistics will be available, if and when the federal government moves into a public works program.

U.S. Makes Training Grants

Medical schools, universities and other qualified training institutions, which may include hospitals, are eligible for a new category of federal financial assistance.

Public Health Service has announced establishment of a General Research Training Grants Program designed to enlarge the reservoir of trained researchers in the health sciences.

"Additional trained research personnel are badly needed," commented Dr. James A. Shannon, director of the National Institutes of Health, which will be the administrative agency "in such shortage areas as pathology, pharmacology, genetics, anesthesiology, epidemiology, biometry, biochemistry, biophysics and

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others from which will come new basic knowledge vital to the conquest of disease.

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Labor Favors Hill-Burton

At its recent biennial convention in Atlantic City, N.J., the AFL-CIO adopted a resolution calling for a 10-year extension of the Hill-Burton program.

It also recommends "an increase in the amounts authorized and appropriated to reflect the increase in the costs of construction since the original ceiling was imposed."

'Medicare' Ward Care Redefined

Use of hospital ward facilities under the Armed Forces Dependents' Medical Care Program ("medicare") has been redefined as follows:

"Ward facilities may be used for pediatric cases whenever this is the normal medical practice. Further, when the attending physician admits his patient to a hospital in which all semiprivate accommodations are occupied, care furnished therein shall be considered as authorized care, but the patient should be transferred to a semiprivate accommodation as soon as possible. Finally, when the patient is admitted to an otherwise eligible institution which furnished only ward accommodations, care furnished therein shall be considered authorized care."

The "medicare" regulation identifies ward care as care in a room containing more than four beds. When a "medicare" dependent is admitted to a hospital having only private rooms, "medicare" will pay 90 per cent of the daily hospital charges or $15 per day, whichever is less.

"Medicare" also ruled that a dependent who is returned to a hospital for a second visit will pay $1.75 per day instead of paying the required first $25 of hospitalization costs. This ruling only applies, however, if the readmission is for the same condition as the first admission or a direct complication thereof, and if readmission occurs within 14 days.

2016 Interns Apply for Commissions

The new draft act provisions to supply physicians, dentists and allied specialists to the armed forces are expected to fulfill defense needs in 1958-59.

Under the plan for hospital residency deferment initiated by Dr. Frank B. Berry, assistant secretary of defense, 2016 interns have applied for commissions, the Department of Defense announced. Of these, 850 said they wished to be deferred for residency training. The remainder want to start military duty upon completion of internship in 1958.

The new draft provision, like the older "doctor draft" it replaced, operates by indirection. The armed forces procure medical and dental "volunteers" by offering reserve commissions in lieu of induction.

Export Quota On Polio Vaccine Set

Department of Commerce has fixed on 5 million c.c. as the export quota for poliomyelitis vaccine in the first quarter of 1958. This is the same as the quota for the fourth quarter of 1957.

In the final three months of 1957, the countries receiving the largest U. S. vaccine consignments were Argentina, West Germany, Spain, Hungary, and Yugoslavia.

PRIVATE HOSPITALS, NURSING HOMES—The monthly report for November 1957 shows the Small Business Administration granted loans to one hospital and five convalescent or nursing homes. All are operated for profit. Recipients and amounts of loans are:

Gardena (Calif.) Hospital, $250,000; Jones Nursing Home, Naugatuck, Conn., $100,000; Cage Nursing Home, Memphis, Tenn., $49,700; Arlington (Minn.) Convalescent Home, $90,000; Troy (Mo.) Nursing Home, $2700; Waddell Convalescent Home, Detroit, $30,000.

INDIAN HOSPITAL CONSTRUCTION—Public Health Service has authorized construction contracts which total nearly $900,000 for improvement and expansion of hospital and housing units on Indian reservations.

The most costly project will be construction of a new heating plant and maintenance shop at the Indian hospital at Tuba City, Ariz. Contract price: $383,002. Among other projects are construction of four field health stations in South Dakota at a cost of $91,734.

ARMY MEDICAL SERVICE CITATION—Los Angeles County Board of Supervisors has adopted a special resolution commending Armed Forces Institute of Pathology for its work in helping to identify victims of a recent plane disaster in the Pacific.

The AFIP sent Captain Vernie A. Stembridge (USAF) (MC) and Captain William M. Crafft (USAF) (MC) to the carrier USS Philippine Sea when it was steaming toward the West Coast last November bearing 19 bodies taken from the sea after wreckage of the Pan American airliner "Romance of the Skies" had been sighted.

The commendation was in recognition of the two officers' painstaking work which resulted in early identification of all of the recovered bodies. Remains of the other 25 victims were not found.

BIRTH RATE RECORD—Near the close of 1957, U. S. Public Health Service predicted that the year's baby crop would set a new record for the seventh straight year. Births in 1957 will number about 4,318,000 it was estimated, or 98,000 ahead of 1956.

These consistent yearly increases are attributed to both the rising numbers of marriages and a trend toward larger families.

The provisional birth rate for 1957 is 25.3 for each 1000 persons in the population, compared with 25.2 in 1956.

NATIONAL NURSE MEETING—Annual meeting of the Committee of Federal Council of Nurses and representatives of American Nurses Association and National League for Nursing was scheduled to be held in Washington on Jan. 13. For the current fiscal year, Col. Inez Haynes, chief of the Army Nurse Corps, is serving as the joint group's chairman.

As in the past, the meeting's purpose was to discuss over-all policies of federal nursing units and coordinate their planning with policies and plans of the ANA and NLN.

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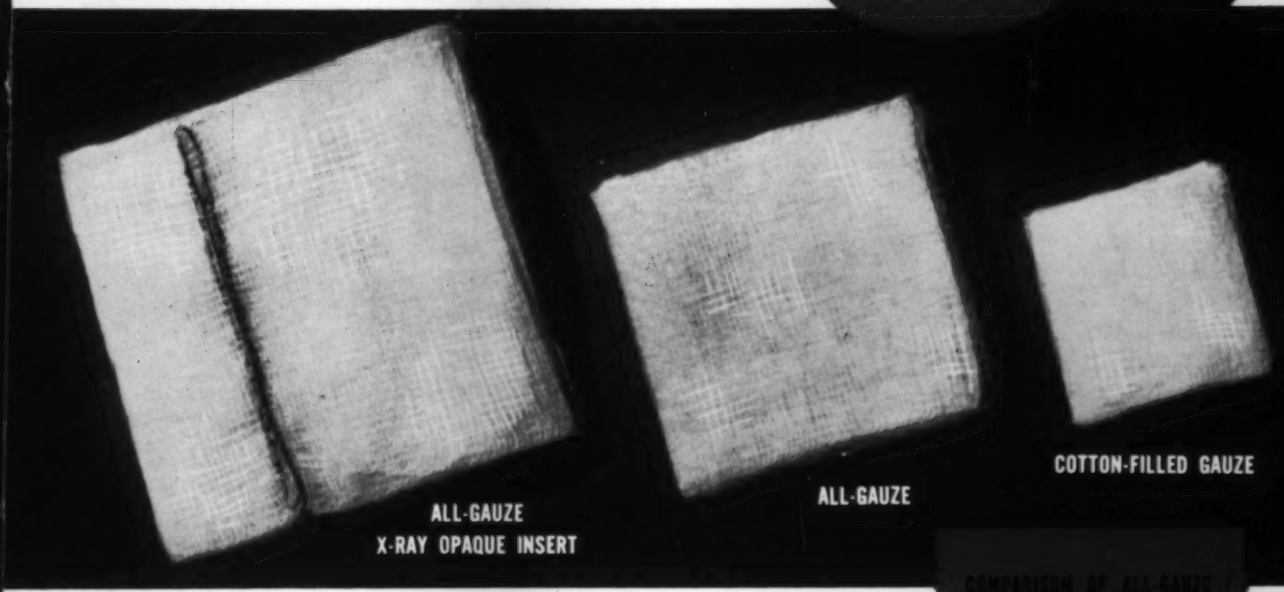

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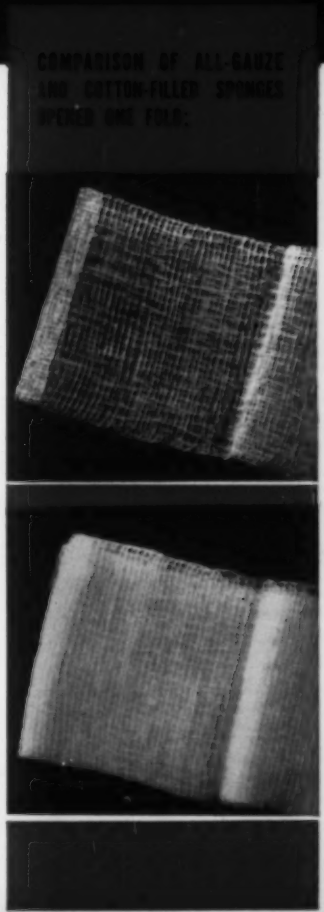

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  - *padding*
- BEDSPREADS
- BLANKETS
  - *Bath*
  - *Crib*
  - *Ether*
- CURTAINS
  - *curtain material*
- DRAPERY MATERIAL
- LAUNDRY FELT
- LINEN MARKERS
- MATTRESS COVERS
- PIECE GOODS
  - *white and colored*
- PILLOWS
- PILLOW CASES
- PILLOW COVERS
- SHOWER CURTAINS
- SHEETS
  - *BED*
  - *CRIB*
  - *bleached*
  - *unbleached*
  - *percale*
  - *contour*
- SHEETING
  - *bleached*
  - *unbleached*
  - *jade green*
- TAPE
- TABLE LINENS
  - *tablecloths*
  - *napkins*
  - *tray covers*
- TICKING
- TOWELS
  - *terry*
  - *huck*
  - *absorbent*
  - *kitchen*
  - *name woven*
- TOWELING
- UTILITY FABRICS
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ECONOMIC RATIO FOUND—

Admission Rates Studied in North Carolina

Hospital admission rates tend to decrease in almost direct proportion to the economic level of a given group. This was one of the conclusions reached by the North Carolina Health Council after a survey to determine the factors affecting the use of general hospital facilities in the state.

Highest hospital admission rates were found among groups which prepay for hospital care through Blue Cross or commercial hospital insurance and the lowest rates were among indigent cases receiving public assistance.

North Carolina's over-all admission rate in 1956 was 118 per 1000 persons. Among Blue Cross subscribers the admission rate was 152 per 1000 subscribers.

The council found that groups with higher admission rates have shorter stays and those with lower admission rates have longer stays.

On the average, the council stated, Blue Cross patients in North Carolina spend 6.1 days in the hospital, compared with 6.5 days for North Carolinians in general and 7.7 for residents of all the United States.

In the lower economic groups the low admission rate indicates, the council stated, "that hospitalization is often postponed until a serious condition develops. This naturally results in a longer stay due to the seriousness of the condition, as well as related factors such as malnutrition, lack of adequate facilities for home care, etc."

CARE OF AGED TRIPLED

Providing medical care for persons over 65 years of age is three times higher than it is for persons under 65 because of both the higher admission rate and the longer average length of stay necessitated by the illnesses of the aged.

"This presents a decided problem," the council observed, "for the average income of persons over 65 years decreases at the time that cost of medical care is at its maximum."

Authors of the council's report predicted that there will be 300,000 persons more than 65 years of age in North Carolina by 1960.

The number of persons in this category in the state has almost doubled in the past 20 years, the council stated.

The council noted that as a result of the program begun in 1946 by the state's Medical Care Commission, North Carolina is almost up to the national average in the number of beds per 1000 population in general and short term hospitals. At the end of 1956, North Carolina had 3.1 beds per 1000 population compared with a national average of 3.5 beds per 1000 population, the council reported.

CONTINUE EXPANSION

Expansion of hospital facilities must be continued, the council stated, to keep pace with the growing as well as aging population. The council also urged that everyone, regardless of economic status, should receive necessary hospital and medical care without delay.

The survey was made by a health council committee composed of state health leaders under the chairmanship of Elisha M. Herndon, executive vice president of the Hospital Care Association (Blue Cross) of Durham. State government, Blue Cross, professional society, and private groups with health field interests cooperated in compiling information for the survey.

New York Council Reports Maternity Ward Rate Rise

Maternity admissions to the wards of New York City hospitals have increased 12 per cent during the last five years while maternity admissions to the private services have steadily declined. This information is contained in a recent report by the Hospital Council of Greater New York.

The shift in other patient departments has been from ward to semiprivate accommodations, the council reported.

Municipal hospitals showed an increase in maternity admissions, proprietary hospitals showed a decrease in such admissions, and voluntary hospitals showed a moderate increase in both private and ward accommodations, the council's report showed.

Although births in New York City hospitals have increased by one per cent during the five-year period, the average stay of maternity patients has been decreasing; the number of days has declined by 2.5 per cent, the council reported.

$7 Million Blow Against Malaria

THIS COUNTRY has made a $7 million contribution to the efforts of two international health agencies, as part of United States voluntary aid in a 60-nation malaria eradication program. Dr. M. G. Candau (left), director general of the World Health Organization, received a check for $5 million on behalf of his organization from U.S. Secretary of State John Foster Dulles (center). Dr. Fred Soper (right), director of the Pan American Sanitary Bureau, serving as WHO regional office for the Americas, accepted a $2 million check.

With the decreased utilization of maternity facilities, New York's hospitals have cut the number of beds assigned to their maternity services by approximately 5 per cent. The occupancy rate of such beds, even with the reduction, is 68 per cent.

"If the rate of occupancy is to reach a level consistent with the effective use of hospitals, further reduction in the number of maternity beds is indicated," the council stated.

Regarding the total number of available beds, the council reported that municipal hospitals showed an increase of 7 per cent, proprietary hospitals a decrease of 20 per cent, and voluntary hospitals a decrease of 7 per cent.

Insurance Companies Adopt Code of Ethical Standards

A code of ethical standards has been adopted by the membership of the Health Insurance Association of America. Under the code each member insurance company pledges to:

1. **Offer** only insurance providing effective and real protection against such loss as the policy is designed to cover.
2. **Write** its policies in clear and direct language without unreasonable restrictions and limitations.
3. **Advertise** its policies in such manner that the public can readily understand the protection offered, and not use advertising which has the tendency or capacity to mislead or deceive.
4. **Select,** train, and supervise personnel of integrity in a manner which will assure intelligent, honest, courteous sales and service.
5. **Engage** only in sales methods, promotional practices and other transactions which give primary consideration to the needs, interest, and continued satisfaction of the persons insured.
6. **Endeavor** to establish the insurability of persons at the time of application in every instance where such insurability is a factor in the issuance or continuance of the insurance or in the liability of the insurer.
7. **Pay** all just claims fairly, courteously, and promptly, with a minimum of requirements.
8. **Continue** research and experimentation in order to meet the changing needs of the public.
9. **Engage** in keen, fair competition so the public may obtain the protection it needs at a reasonable price.

HIAA is an association of 262 United States and Canadian commercial insurance companies in the health insurance field.

$3.6 Billion Premium Paid To Health Insurance Firms

Preliminary estimates by the Social Security Administration indicate that a total premium income of $3.6 billion accrued in 1956 to all forms of health and hospital insurance firms.

Their expenditures for provision of medical, surgical, and hospital care was approximately $3 billion.

Thirty-one per cent of premium income went to Blue Cross Plans; 13 per cent to Blue Shield Plans; 36 per cent to companies underwriting group insurance; 18 per cent to individual insurance underwriters, and the remainder to miscellaneous community plans.

Two-thirds of all premium income was assignable to hospitalization and the remainder to physicians' services.

Hospitalization accounted for more than two-thirds of the benefit payments in 1956 by all types of voluntary health insurance plans, commercial and nonprofit. In money, this came to approximately $2 billion, with the nonprofits—chiefly Blue Cross—disbursing somewhat more than 50 per cent of the total.

Health Insurance Growth Accelerating, Group Finds

At the end of 1956, there were 66.3 million persons covered for hospital expenses through individual and family health policies and through group insurance programs, a 79 per cent increase over the 1950 total of 37 million. This information was compiled by the Health Insurance Institute and is exclusive of those covered by Blue Cross Plans.

The institute reported that the trend over the past three years has been a constantly accelerated rate of expansion in hospital expense protection. In 1954 there was an increase of 5.9 per cent in the number of people covered, over the number covered in 1953; the percentage gain in 1955 over 1954 was 7.9 and the rate of growth in 1956 over 1955 was 11.1 per cent.

Some 63 million persons had surgical expense protection last year, the institute reported; the number of people protected rose 91 per cent during the six-year period 1950-56. The rate of growth in surgical coverage in 1954, the institute stated, was 4.6 per cent over 1953; in 1955 the increase was 7.3 per cent over 1954, and 1956 was 11.2 per cent greater than for the comparable period in 1955.

The number of persons with regular medical expense coverage, providing for doctor visits for nonsurgical care, rose by 281 per cent between 1950 and 1956. By the end of last year approximately 29.8 million persons had this type of insurance.

Approximately 8.9 million persons had major medical care coverage in 1956 compared with 689,000 who had it in 1952 and the estimated 10 million who had it as of May 1957, the institute reported.

Sloan Institute Inaugurates New Administrative Program

An advanced management program for hospital administrators and executives of allied agencies will be held from July 7 to Aug. 15 by the Sloan Institute of Hospital Administration at Cornell University, Ithaca, N.Y.

Issues affecting administrative decisions in the health care field are to be explored under the new program, made possible by a grant from the Alfred P. Sloan Foundation. Attention is to be given to "evolving theories of administration, the results of current research, and important trends in health care programs."

The program is primarily designed for hospital administrators in the 31 to 45 age range who have had upwards of five years of responsible administrative experience. Consideration is also to be given to assistant administrators holding positions of unusual responsibility and to executives of hospital councils, associations, state agencies, and Blue Cross Plans. Demonstration of professional or civil leadership will be a criterion of selection.

Approximately 20 applicants will be accepted for the program. Deadline for applying is March 31. A charge of $100 will be made against the participant or his sponsor, with the major cost of the program met from the grant funds. Applications and further information are available from the Sloan Institute.

Reed Takes Sloan Post

Louis S. Reed, Ph.D., has been appointed associate professor of medical economics at the Sloan

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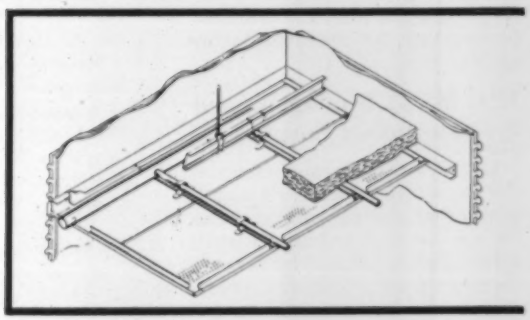

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Institute of Hospital Administration, Cornell University. Mr. Reed has held positions as Public Health Service health economist, professor of economics, and economic analyst for the federal government.

Foundation Gives $100,000 For Educational Program

A grant of $100,000 has been given to St. Louis University and the Catholic Hospital Association by the W. K. Kellogg Foundation to be used to extend CHA's program of continuing education for hospital department heads and other hospital supervisory personnel.

CHA inaugurated the program of continuing education in September 1957. The grant will help provide formal classes in all hospital areas, professional and service, presenting the latest developments and techniques applicable to any given area.

Since September, the Catholic Hospital Association's department of continuing education has given three programs — one for nurse anesthetists, another for hospital housekeepers, and a workshop in hematology for medical technologists.

Miss M. A. Dunlap Named To Association Position

Dr. Edwin L. Crosby, director of the American Hospital Association, has announced the appointment of **Mary A. Dunlap** as assistant librarian. Miss Dunlap, a graduate of the University of Oklahoma program in library science, was formerly executive secretary of the Alexander Graham Bell Association for the Deaf, Washington, D.C., and editor of the *Volta Review*, monthly periodical dealing with problems of the deaf.

Inhalation Therapists Elect

The American Association of Inhalation Therapists held its annual meeting Nov. 4-8 in Cleveland and elected the following officers: president, James E. Peo, supervisor of inhalation therapy at Delaware Hospital, Wilmington; first vice president, Don Gilbert, chief inhalation therapist, University of Michigan Hospital, Ann Arbor; second vice president, Lawrence Fruik, chief inhalation therapist, Edgewater Hospital, Chicago; secretary-treasurer, Agnes Forrest, Edgewater Hospital, Chicago.

New Council Formed

The Washington State Hospital Association has reported that the North Central Washington Hospital Council has been organized. Officers are: president, Dan Chapman, administrator, Lake Chelan Community Hospital, Chelan; vice president, Maurice Click; business manager, Central Washington Deaconess Hospital, Wenatchee; secretary, Doris Benson, St. Anthony's Hospital, Wenatchee.

Hospitals in Wenatchee, Chelan, Leavenworth, Brewster, Tonasket, and Omak are included in the council's area.

Address Change Made

Zella Messner, secretary of the South Dakota Hospital Association, has reported that the association's new address is the St. Charles Hotel, Pierre, S. Dak.

Hospital Anniversary Marked By Washington Association

The Washington State Hospital Association, celebrating 25 years of service, has issued a 120 page book commemorating its anniversary and the 100th anniversary of the establishment of the first permanent hospital in the Pacific Northwest. (The hospital: St. Joseph Hospital, established by the Sisters of Charity of Providence, Montreal, in Vancouver, Washington Territory, June 7, 1958.)

Hospital milestones in Washington are detailed in the book. Also included are a summary of the growth of hospitals in the state, a history of the association, a note of appreciation to the Ford Foundation, and a comprehensive directory of nonfederal hospitals in the state, with a picture and a brief history of each.

17 GROUPS REPORT—

Hospital Organizations Elect Officers

Arizona Hospital Association: president, J. L. Cline, administrator, Gila County Hospital, Globe; vice president, Florence L. Ladner, administrator, Hoemake Cooperative Hospital, Casa Grande; secretary-treasurer, G. M. Hanner, administrator, Good Samaritan Hospital, Phoenix.

Hospital Council of the National Capital Area: president, Sister Mary Evangelist, S.C.N., administrator, Georgetown University Hospital, Washington; president-elect, Adm. Warwick T. Brown, USN, ret., administrator, Washington Hospital Center, Washington; secretary, William M. Bucher, executive director of the council.

Florida Hospital Association: president, Steve F. McCrimmon, administrative director, Miami Baptist Hospital, Miami; president-elect, T. L. Jacobsen, administrator, Morton F. Plant Hospital, Clearwater; secretary-treasurer, Harry M. Weir, administrator, Seminole Memorial Hospital, Sanford.

Idaho Hospital Association: president, Sister Alma Dolores, administrator, St. Alphonsus Hospital, Boise; president-elect, John W. Hayman, administrator, Caldwell Memorial Hospital, Caldwell; secretary-treasurer, John B. Ernsdorff, business manager, St. Joseph's Hospital, Lewiston.

Illinois Hospital Association: president, Rev. John Weishar, director of Catholic hospitals, Diocese of Peoria; president-elect, Ray E. Brown, superintendent, University of Chicago Clinics; first vice president, Delbert L. Price, administrator, Children's Memorial Hospital, Chicago; second vice president, Charles R. Freeman, administrator, Alton Memorial Hospital, Alton.

Minnesota Hospital Association: president, Dr. B. W. Mandelstam, administrator, Mt. Sinai Hospital, Minneapolis; president-elect, Sister Francis Xavier Forster, administrator, St. Cloud Hospital, St. Cloud; first vice president, Frank R. Briggs, administrator, Abbott Hospital, Minneapolis; second vice president, Dorothy L. Petsch, administrator, Worthington Municipal Hospital, Worthington; secretary, Glen Taylor, business manager, Students' Health Service, University of Minnesota, Minneapolis; treasurer, James W. Stephan, assistant director, course in hospital administration, University Hospitals, Minneapolis.

Missouri Hospital Association: president, Gilbert O. Lindgren, administrator, Trinity Lutheran Hospital, Kansas City; president-elect, Sister Mary Bertrand, administrator, St. John's Hospital, Springfield; vice president, Keyton Nixon, administrator, Audrain County Hospital, Mexico; secretary, Ted O. Lloyd, association executive director; treasurer, Norman McCann,

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assistant administrator, Missouri Baptist Hospital, St. Louis.

Montana Hospital Association: president, George Pendergraft, administrator, Glacier County Memorial Hospital, Cut Bank; president-elect, Robert Howe, administrator, Billings Deaconess Hospital, Billings; vice president, Sister John Baptist, administrator, St. John's Hospital, Helena; secretary-treasurer, Donald Showman, administrator, Kennedy Deaconess Hospital, Havre.

Nebraska Hospital Association: president, Gerald L. Aldridge, administrator, Mary Lanning Memorial Hospital, Hastings; president-elect, Joseph O. Burger, trustee, Nebraska Methodist Hospital, Omaha; vice president, Eugene G. Edwards, administrator, Bryan Memorial Hospital, Lincoln; secretary, Edward D. Wilken, trustee, Mary Lanning Memorial Hospital, Hastings; treasurer, Sister Mary Gertrude, administrator, St. Mary's Hospital, Columbus.

Hospital Administrative Council of Nevada: president, Sister M. Seraphine, O.P., St. Mary's Hospital, Reno; president-elect, Mrs. Whilleta Whomes, administrator, Churchill Public Hospital, Fallon.

Oklahoma Hospital Association: president, Karey Fuqua, administrator, Southwestern Clinic Hospital, Lawton; president-elect, Art Coltrin, administrator, Jane Phillips Memorial Hospital, Bartlesville; vice president, Tom Carter, director, Baptist Hospital of Oklahoma, Oklahoma City; secretary, Raymond Crews, administrator, Oklahoma University Medical Center, Oklahoma City; treasurer, James Harvey, Hillcrest Medical Center, Tulsa.

Hospital Council of Western Pennsylvania: president, John T. Ryan, board president, Pittsburgh Hospital, vice president, Children's Hospital, advisory board member, Mercy Hospital, all Pittsburgh; vice president, Edward J. Magee, member, board of trustees, Elizabeth Steel Magee Hospital, Pittsburgh; secretary, William A. Hacker, administrator, McKeesport Hospital, McKeesport; treasurer, Sidney M. Bergman, executive director, Montefiore Hospital, Pittsburgh.

South Dakota Hospital Association: president, Horace Atkin, administrator, Community Memorial Hospital, Redfield; president-elect, Sister M. Rosaria, administrator, Sacred Heart Hospital, Yankton; secretary-treasurer, Zella C. Messner, association secretary.

Virginia Hospital Association: president, Harvie M. Clymer, administrator, Shenandoah County Memorial Hospital, Woodstock; president-elect, W. C. Bloxom, administrator, Stuart Circle Hospital, Richmond; secretary, W. R. Reid, administrator, Jefferson Hospital, Roanoke; treasurer, Roscoe B. Rhoads, administrator, Loudoun County Hospital, Leesburg.

Washington State Hospital Association: president, Charlotte C. Dowler, administrator, Shelton General Hospital, Shelton; president-elect, Raymond F. Farwell, administrator, Swedish Hospital, Seattle; first vice president, Harry C. Wheeler, administrator, Deaconess Hospital, Spokane; second vice president, Mrs. Edra L. Mayo, administrator, Brining Memorial Hospital, Dayton; third vice president, Sister Miriam, administrator, St. Joseph Hospital, Aberdeen; treasurer, Alice W. Sandstrom, business manager, Children's Orthopedic Hospital, Seattle.

Associated Hospitals of Alberta: president, Chief Judge Nelles V. Buchanan, courthouse, Edmonton; vice president, Dr. H. P. Wright, Calgary; secretary-treasurer, L. R. Adshead, University Hospital, Edmonton.

British Columbia Hospitals' Association: president, L. F. C. Kirby, director, Royal Columbia Hospital, New Westminster; first vice president, J. H. Hargrave, president, board of management, Trail-Tadanac General Hospital, Trail; second vice president, H. R. Slade, administrator, General Hospital, Powell River.

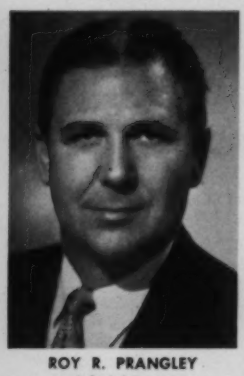
Ontario Hospital Association: president, H. M. Jackson, trustee, Norfolk General Hospital, Simcoe; president-elect, Rev. James Ferguson, trustee, Royal Victoria Hospital, Barrie; vice president, Sister M. Imelda, superintendent, St. Joseph's Hospital, London; vice president, Dr. J. E. Sharpe, superintendent, Toronto General Hospital, Toronto; vice president, M. B. Wallace, general superintendent, Toronto Western Hospital, Toronto.

State Association Presidents

CALIFORNIA

RICHARD HIGHSMITH
Administrator
Samuel Merritt Hospital
Oakland
(226 beds)

COLORADO



ROY R. PRANGLEY
Administrator
St. Luke's Hospital
Denver
(436 beds)

MISSISSIPPI

DR. DAVID B. WILSON
Director
University Hospital
Jackson
(355 beds)

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PENNSYLVANIA
Allentown—Muhlenberg Medical Center.

TEXAS
Arlington—Arlington Memorial Hospital Foundation.

HAITI
Saint Marc—Hospital Albert Schweitzer.

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Allmand, Charles M.—student—hosp. admin. program—University of Michigan—Ann Arbor.
Anderson, Sandy—student—hosp. admin.—Grady Memorial Hospital—Macon, Ga.
Anstey, E. Thomas—chief eng.—Griffin Hospital—Derby, Conn.
Bangs, A. Harold—dir. of plant and services—Memorial Hospital—Colorado Springs, Colo.
Bosworth, C. L.—purch. agent—Charles S. Wilson Memorial Hospital—Johnson City, N.Y.
Bowman, L. Grady—plant eng.—Mercy Hospital—Charlotte, N.C.
Bryan, L. A. Jr.—asst. business admin.—Dhahran Health Center—Aramco Dhahran—Saudi Arabia—medical department 807-39-28-A—c/o NY International Airport—Hangar No. 6, Jamaica, N.Y.
Carb, Saul—student—Columbia University—New York City.

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No. S-30	3½ Qts.	12¼" x 3⅜"
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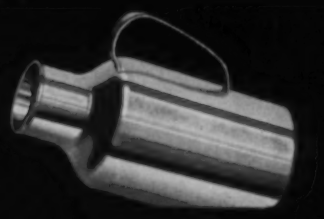

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No. S-020 — 2 Qts. — 4½" x 6⅜"

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No. S-15	14" x 11½" x 4"

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No. S-75	24 ozs.	5" x 2½"
No. S-106	40 ozs.	6¼" x 2¾"
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No. S-7 7 ozs. 3"x3"

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Caven, E. Charles—research assoc., American Hospital Association Hospital Research and Educational Trust—Chicago.
Clippinger, Malcolm M.—student—graduate School of Public Health—University of Pittsburgh.
Cooke, I. R.—maint. supt.—Leigh Memorial Hospital—Norfolk, Va.
Denton, O. William—eng.—Cottage Hospital—Grosse Point Farms, Mich.
Ferguson, Matthew Ray—grad. student—Michigan State University—East Lansing.
Fought, Floyd J.—purch. agent—St. Lawrence Hospital—Lansing, Mich.
Gessner, Stephen G. Jr.—business mgr.—Hospital of St. Raphael—New Haven, Conn.
Gieselmann, E. Paul—exec. eng.—Methodist Hospital—Memphis, Tenn.
Gisborn, C. Thomas—hosp. eng.—Ireland Army Hospital—Fort Knox, Ky.
Goldberg, Alvin—student—hosp. admin.—Grady Hospital, Atlanta.
Halbrook, D. Duane—dir. of maint.—Douglas County Hospital—Omaha, Nebr.
Hoefer, E. Earl—chief eng.—Oswego (N.Y.) Hospital.
Jameson, Bradford—student hosp. admin.—University of Michigan—Ypsilanti.
Kluge, M. Anthony—chief eng.—Elmhurst (N.Y.) General Hospital.
Kolber, Esther G.—exec. sec. to admin.—St. Francis Hospital—Evanston, Ill.
Lewis, James E. Lt. Col.—student hosp. admin.—Fort Sam Houston, Tex.
Lewis, W. Harold—chief eng.—St. Josephs Hospital—Augusta, Ga.
Lovering, E. Walter—supv. of maint.—New England Baptist Hospital—Boston, Mass.
Lukashok, Herbert—student hosp. admin.—Columbia University—New York City.
Lynk, F. Leo—chief eng.—St. Francis Hospital—Evanston, Ill.
Magill, Andy F.—purch. agent—Wesley Hospital and Nurse Training School—Wichita, Kans.
Michael, M. Guy—purch. agent—West Seattle (Wash.) General Hospital.
Mondano, Frank—eng. officer—Soldiers Home (Quigley Hospital)—Chelsea, Mass.
McCarthy, J. Francis Jr.—supv. hosp. hskpg.—Dhahran Health Center—Aramco Dhahran—Saudi Arabia, medical department 807-39-28-A—c/o NY International Airport Hangar No. 6 Jamaica, N.Y.
McLaughlin, F. Joseph—chief eng.—Hahnemann Hospital—Washington, D.C.
Neil, George—eng.—St. Anthony Hospital—Carroll, Iowa.
Nolan, Franklin William—maint. eng.—Hamilton Memorial Hospital—Dalton, Ga.
Ott. Frank—stationery chief eng., St. Michaels Hosp., Stevens Point, Wis.
Paulson, F. William—chief eng.—St. Michael's Hospital—Grand Forks, N. Dak.
Shaw, G. Elbert Jr.—student—Georgia State College of Business Administration—Atlanta.
Shirtz, Thomas—student—Northwestern University—Chicago.
Stieler, M. Scott—maint. mgr.—Marlette (Mich.) Community Hospital.
Steinman, A. Henry Jr.—chief eng.—St. Vincent DePaul Hospital—Norfolk, Va.
Thurston, A. Walter—chief eng.—Emanuel Hospital—Portland, Ore.
Toney, B. Frank—chief eng.—Greater Bakersfield (Calif.) Memorial Hospital.
Warren, S. Richard—student hosp. admin.—School of Public Health and Administrative Medicine—Columbia University—New York City.
Wilkinson, H. David—chief eng.—Jewish Memorial Hospital—New York City.
Willey, R. Christine R.N.—purch. agent—Mercy Hospital—Redding, Calif.

Hospital association meetings

(Continued from page 8)

Ohio Hospital Association—March 10-13; Cincinnati (Netherland-Hilton Hotel)
Hospital Association of Pennsylvania—May 21-23; Atlantic City, N. J. (Convention Hall)
Comite des Hopitaux du Quebec—June 25-27; Montreal (Montreal Show Mart)
South Carolina Hospital Association—April 24-25; Roanoke, Va. (Hotel Roanoke)
Tennessee Hospital Association—March 13-15; Chattanooga (Hotel Patton)
Texas Hospital Association—May 5-8; Dallas (Statler-Hilton Hotel)
Wisconsin Hospital Association—March 13; Milwaukee (Hotel Schroeder)

AHA INSTITUTES

(THROUGH JUNE 1958)

Dietary Department Administration—January 20-24; Dallas, Tex. (Adolphus Hotel)
Institute for Nurse Anesthetists—January 20-24; Omaha, Nebr. (Sheraton-Fontenelle Hotel)
Nursing Supervision—February 10-13; Chicago (Shoreland Hotel)
Hospital Planning and Organization Workshop—February 17-21; Louisville (Sheraton-Seelbach Hotel)
Personnel Administration for Hospitals—March 3-7; Birmingham, Ala. (Holiday Inn)
Hospital Laundry Management and Operation—March 12-14; Houston (Shamrock Hilton Hotel)
Institute on Disaster Planning—March 12-14; Boston (Somerset Hotel)
Nursing Service Administration—March 24-28; Detroit (Fort Shelby Hotel)
Hospital Engineering—April 7-11; Kansas City, Mo. (Bellerive Hotel)
Nursing-Dietary-Housekeeping—April 7-11; Chicago (Edgewater Beach Hotel)
Planning and Working Together—Dietary, Housekeeping and Nursing Department Directors—April 7-11; Chicago (Edgewater Beach Hotel)
Medical Record Library Personnel—April 14-16; Seattle, Wash. (Benjamin Franklin Hotel)
Obstetrical Nursing Service Administration—April 28-May 1; New Orleans (Hotel Monteleone)
Occupational Therapy Institute—April 28-May 2; Boston (Somerset Hotel)
Hospital Auxiliary Leadership—May 6-8; Chicago (Edgewater Beach Hotel)
Central Service Administration—May 12-15; Pittsburgh (Roosevelt Hotel)
Nursing Inservice Program—May 26-29; Colorado Springs, Colo. (Antlers Hotel)

Hospital Engineering—April 7-11; Kansas City, Mo. (Bellerive Hotel)
Medical Record Library Personnel—April 14-16; Seattle, Wash. (Benjamin Franklin Hotel)
Obstetrical Nursing Service Administration—April 28-May 1; New Orleans (Monteleone Hotel)
Occupational Therapy—April 28-May 2; Boston (Somerset Hotel)
Hospital Auxiliary Leadership—May 6-8; Chicago (Edgewater Beach Hotel)
Central Service Administration—May 12-15; Pittsburgh (Roosevelt Hotel)
Nursing Inservice Program—May 26-29; Colorado Springs, Colo. (Antlers Hotel)

ASSOCIATION SECTION

(Continued from page 54)

hospitals and other facilities authorized by Title VI of the Public Health Service Act have reduced and will further reduce, but have not eliminated and cannot soon eliminate, the shortage of physical facilities for furnishing adequate hospital, clinic, and similar services to all the people. Grants for renovation and modernization authorized by Part I above will reduce, but cannot soon eliminate, obsolescence of existing facilities. Many additional projects for the construction or for the renovation and modernization of hospitals or other facilities can be carried out with the aid of loans at a low rate of interest, and state programs for the construction and for the renovation and modernization of hospitals and other facilities can be carried more rapidly toward completion with the aid of federal loans for such purposes.

Legislation developed for this part should include the following principles:

1. Congress should further amend Title VI of the Public Health Service Act to establish a long-term, low interest rate program to supplement the grant-in-aid programs.

2. This loan program should cover new construction as well as renovation and modernization of existing facilities. The types of facilities covered should be coextensive with the types of facilities covered under the grants-in-aid programs.

3. No loan should exceed 80 per cent of the cost of construction or

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How Wilmot Castle units sterilize at top speed

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Monel alloy and Nickel-clad steel go a long way in assuring the quick, trouble-free operation of Castle units. These smooth, solid metals resist corrosion by saline solutions, steam, organic debris and cleansers. Surfaces remain smooth, easy to clean. There's no peeling or warping despite the extremes of temperature encountered daily. Both metals are easily welded, eliminating need for riveted construction and possible leakage.

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renovation or modernization. Loans should be at a low rate of interest, possibly 1.5 per cent but not to exceed 2 per cent, and should extend for not more than 30 years.

4. To be eligible, an application for a loan for either construction or modernization must be made pursuant to an approved state plan. The application should be submitted to the surgeon general through the same state agency administering the grants-in-aid program. No federal loan shall be granted on a project where a federal grant has already been made. Similarly, no such grant shall be made for a project where a loan has been made.

5. To obtain funds for loans for this part, the surgeon general, with the approval of the secretary of the Department of Health, Education, and Welfare, should have the authority to issue, and have outstanding at any one time, notes and obligations in an amount not to exceed $500 million.

6. The secretary of the Treasury should be authorized and directed to purchase any notes and obligations of the surgeon general issued under this part and he should be authorized to sell bonds to the public to finance such purchases.

7. Projects in any one state should not exceed more than 5 per cent of the total funds authorized under this program.

8. The loans should be made directly by the federal government to the borrowers. The program should not be one of federally guaranteed mortgage loans.

9. Loans shall not be made for the purpose of refinancing existing indebtedness.

Part III—Extension of the Hospital Survey and Construction Act

The Hospital Survey and Construction Act, including the new parts now proposed, should be extended for an additional five years, to June 30, 1964.

The following abstracts summarize actions of the Board of Trustees of the American Hospital Association on the subject of release of medical information by hospitals.

June 22, 1951, the Board of Trustees resolved:

"That there is objection to the release of confidential information concerning the health of patients, and that the Association continue to support the principle that confidential health records should be protected; further, that the American Public Welfare Association be advised of this action."

The *Manual of Admitting Practices and Procedures* published by the American Hospital Association, and approved by the Board of Trustees June 22, 1951, includes these statements:

"The medical records and information obtained by the physician while attending a patient in the hospital are all of a confidential character. This data should not be disclosed to anyone without the consent of the patient or the person who represents the patient. The information on the patient's chart is protected by a privileged communication statute in some states. Where such a statute exists, this data is inadmissible as evi-

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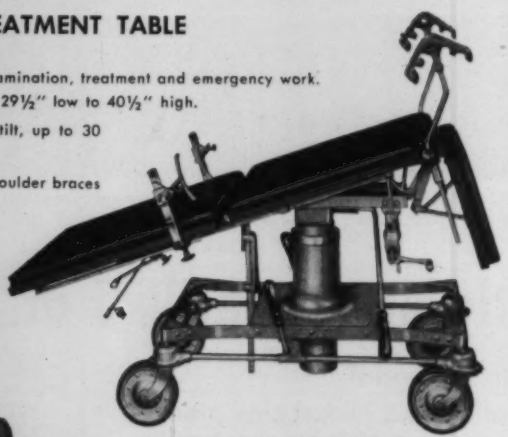

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dence in all legal cases where the privilege has not been waived, except when admitted by subpoena.

"It is customary for the patient to disclose all pertinent information about his malady to enable his physician to diagnose and treat the condition. Sometimes this information is so personal that if it is freely circulated throughout the hospital it may prove both embarrassing and detrimental to the patient. In recognition of this fact, statutes have been enacted in many states protecting the patient from disclosure of such confidential communications in judicial proceedings, except upon his consent.

"These statutes recognize the fact that the patient may be somewhat handicapped in his relationship with his physician. For example, the patient may be suffering from pain or weakness, distracted by it, ignorant of the nature or extent of his injury or illness, driven by necessity to call in a professional adviser, often with relatively little freedom of choice, and obliged to submit to the more intimate disclosure involved in physical examination. The physician, on the other hand, is in full possession of his faculties. Manifestly, the patient, at this time, occupies a dependent position. The statutes are intended to encourage full and frank personal disclosures of physical conditions by relieving the patient from fear of embarrassing consequences.

"The ward or charity patient is entitled to the same protection in every respect as a private or pay patient."

Government requests for information studied in 1953.

In 1953 the Council on Professional Practice considered the problem of unwarranted demands for medical records by government agents and was of the opinion that hospital medical records should not be released to government agents unless the patient has consented or there has been a subpoena issued. No formal recommendation was made and consequently the Board of Trustees did not have the occasion to take any official action.

Feb. 8, 1956, the Board of Trustees passed the following resolution:

"To adopt the following state-

More Comfort for the Patient
More Time for the Nurse

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"PUSH-BUTTON" Hilow Bed

Hill-Rom Safety Sides do not interfere with use of the patient control panel.

Procedure Manual No. 3—"Hilow Beds," by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom. Copies for student nurses and graduate nurse staff will be sent on request.

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ment concerning the use of medical records:

"Recognizing that patients can obtain the greatest benefits of medical science only where there is free exchange of scientific and medical knowledge; that much of such knowledge is contained only in the medical records of patients, the American Hospital Association recommends to hospitals that provision be made in the constitution and bylaws of the hospital that:

1. Free access to all medical records of all patients be afforded to staff physicians in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient.
2. Subject to the discretion of the administrator, former members of the medical staff be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital."

The following paragraph is from "Ethical and Administrative Principles for Hospitals" approved by the Board of Trustees, May 1957:

"Fully recognizing that the press, radio and other communication media are excellent vehicles of public education and have a responsibility to disseminate information to the community, the hospital must appreciate its moral obligation to the patient and to the professional groups represented in its organization. Consequently, information about patients, except as required by law or where privileged communication is involved, should not be given without the consent of the patient or the patient's immediate family and the patient's physician."

What the community expects of the hospital

(Continued from page 52)

operating an outpatient department. Prompt treatment, which outpatient service makes possible, may avert overcrowding the hospital with inpatients.

Another practice with similar results is "home care" for people who are too ill to visit the outpatient department, yet require less professional supervision than is furnished in a general hospital. Public health nurses, visiting nurses or trained family members may assist a hospital's staff in providing this care. All necessary medical direction is provided without the expense (to the patient, his family or the public) of maintaining a bed in a general hospital.

In fact, in all of the above areas —and many more—hospital administrators have opportunities to blend together the best attributes of medical care with community service. It is the time to establish the general hospital's position as medical and health center for the community. ■

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3. Faxton, N. W. *The Hospital in Contemporary Life*. Cambridge, Harvard Univ. Press. 1948.
4. Goldwater, S. S. *On Hospitals*. New York, Macmillan, 1947.

The P&S model M-8 is one of 27 stainless steel cabinets and tables in modern design. All drawers are equipped with ball bearing slides. Formica tops available in 8 colors. Electrical and air units in other models are suitable for both the EENT as well as the General Practitioner.

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PRO RE NATA

JOHN H. HAYES

The hospital at Gonesse, France, near Paris, established in 1208, gives to the mother of each newborn baby half a bottle of champagne. They say that the first thing a new father does is to go out and buy a bottle of champagne. Why shouldn't the mother have some too? The economic director of the hospital (we call him the administrator) says, "Many modern hospitals have forgotten that if you're comfortable mentally and emotionally you're better off physically."

In this country the "old man" goes out and buys cigars. I'm not suggesting that we give cigars to the mothers, but we ought to do something. How about a Martini? For twins, a double Martini; for triplets, a bottle of Three Feathers; for quadruplets, Four Roses, etc.

Anyone for 7-UP?

★ ★ ★

If you want to find out how fast time can really fly, try preparing a column like this for two issues each month.

★ ★ ★

The lab, in the month of July,
Missed a rabbit; and did not know why.
That's no way to act.
Rabbits do not subtract;
But, Boy, they can sure multiply.

★ ★ ★

The psychiatrist told him to lie
On the couch; but the patient said, "My!
Why should I do the resting
The while you are testing?
You rest. You're much older than I."

★ ★ ★

A hospital in New Jersey is now using colors in the plaster in casts for fracture cases, as a means of pleasing such patients. (See page 28) Bandaid manufacturers use colors and pictures on their product to please the children.

Next we will have pastel shades in cotton balls, varicolored tongue depressors and, perhaps, plaid gauze for Scottish patients.

★ ★ ★

SNAKE HOLLOW HOSPITAL NOTES: When the fat man from the recent circus was brought in as a mental patient, one of our wits said he was a monu-mental case.

Roy Snodgrass, who had Blue Cross, Blue Shield and four other hospital and health policies, has now been discharged from the hospital and has bought a new car.

When the ski season was over, our orthopedist, Dr. Thomson, departed on vacation.

★ ★ ★

It is said that we are all brothers. That may be true; but it's no reason why we should act that way.

★ ★ ★

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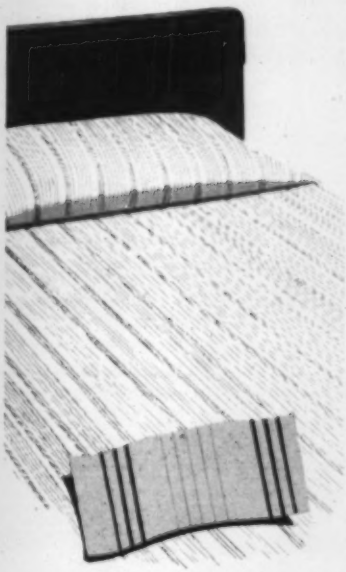

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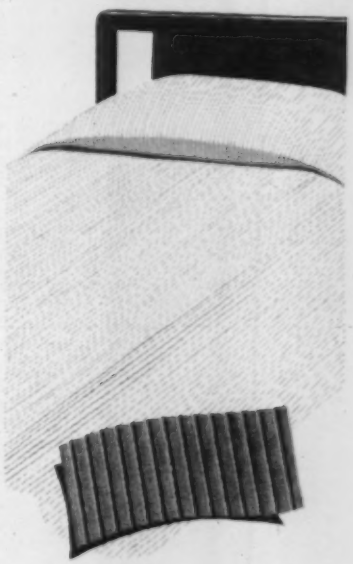

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SALES HELP WANTED—Leading eastern manufacturer has a new concept in industrial maintenance finishes and is seeking capable individual to promote and sell his system. You operate from our regional office near your city. Excellent opportunity for the right man. Experience in selling industrial finishes desirable but not absolutely necessary. Excellent salary and profit-sharing arrangement commensurate with ability. Reply to Box I-9, HOSPITALS.

PUBLIC RELATIONS position in health field. General writing skills plus knowledge of visual media wanted. List experience in application, including salary expected. Address HOSPITALS, Box I-12.

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Part II of August 1 issue

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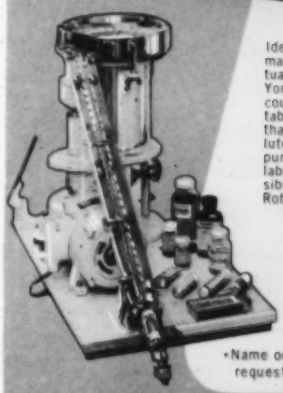

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ADVERTISER'S INDEX - - - - - January 16, 1958

Abbott Laboratories .....20 and Facing Page 20
Air-Shields, Inc. 4
American Cyanamid Company
Surgical Products Division 1
American Gas Association 13
American Laundry Machinery Co. 66, 67
American Sterilizer Company 35
Armour Laboratories
A Division of Armour and Company 89

Bates Fabrics, Inc. 109
Bauer & Black
Division of The Kendall Company 65
Baxter Laboratories, Inc. .....72, 73, Third Cover
Becton, Dickinson & Company 23
Blickman, Inc., S. 34
Brewer Company, E. F. 77
Bristol-Myers Company 57
Burgess-Manning Company 99
Burnet Company, The 111

Carnation Company 85
Carolina Absorbent Cotton Company ..Facing Page 96
Chesebrough-Pond's, Inc. 8
Classified Advertising 110, 111
Coca-Cola Company 81
Cook Machinery Company, Inc. 75
Crimsco, Inc. 83
Cutter Laboratories 53

Don & Company, Edward 108

Eastman Kodak Company 95

Fisher Scientific Co. 30
Fleet Co., Inc., C. B. 91

General Electric Company, X-Ray Dept. 24, 25
Goodrich Industrial Products, Inc., B. F. 21
Gudebrod Bros. Silk Co., Inc. 59
Guide for Hospital Buyers 111

Haney Associates Inc. 90
Hausted Manufacturing Company .....Second Cover
Hill-Rom Company 107
Hobart Manufacturing Company 16
Hoffmann-LaRoche, Inc. 36
Hollister Company, Franklin C. 26
Huntington Laboratories 92
Hyland Laboratories 12

International Nickel Company, Inc. 105

Jarvis & Jarvis, Inc. 18
Johnson & Johnson .....Facing Page 68

Koenigkramer Company, F. & F. 106

Lilly & Company, Eli 2

McKesson & Robbins, Inc. 5
Meals-On-Wheels 83
Meinecke & Co., Inc. 70
Mueller & Company, V. 58

National Cylinder Gas Company 14, 15

Organon, Inc. 61
Otis Elevator Company 10, 11

P & S Medical Equipment 108
Parke, Davis and Company .....Fourth Cover
Physicians' Record Company 68
Picker X-Ray Corporation 9
Plextone Corporation of America 29
Polar Ware Company 103
Procter & Gamble 71
Puritan Compressed Gas Corp. 101

Relax-A-Bed Corp. 93
Rich Company, John F., The 111
Roche Laboratories
Division of Hoffmann-LaRoche, Inc. 36

Sexton & Company, John 79
Simmons Company .....Facing Page 18
Squibb & Sons, E. R. 63

Travenol Laboratories, Inc.
Pharmaceutical Products Div. of
Baxter Laboratories, Inc. .....Third Cover

Vestal, Inc. 32, 33

Wallace Laboratories, Inc. 55
West Chemical Products, Inc. 31
Westinghouse Electric Corp.
X-Ray Department 27
Wilson Rubber Company
Division of Becton, Dickinson & Company 23
Wyeth Laboratories 6, 7

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*Bugash, R. C., Director Pharmacy Dept., Lenox Hill Hospital: personal communication.

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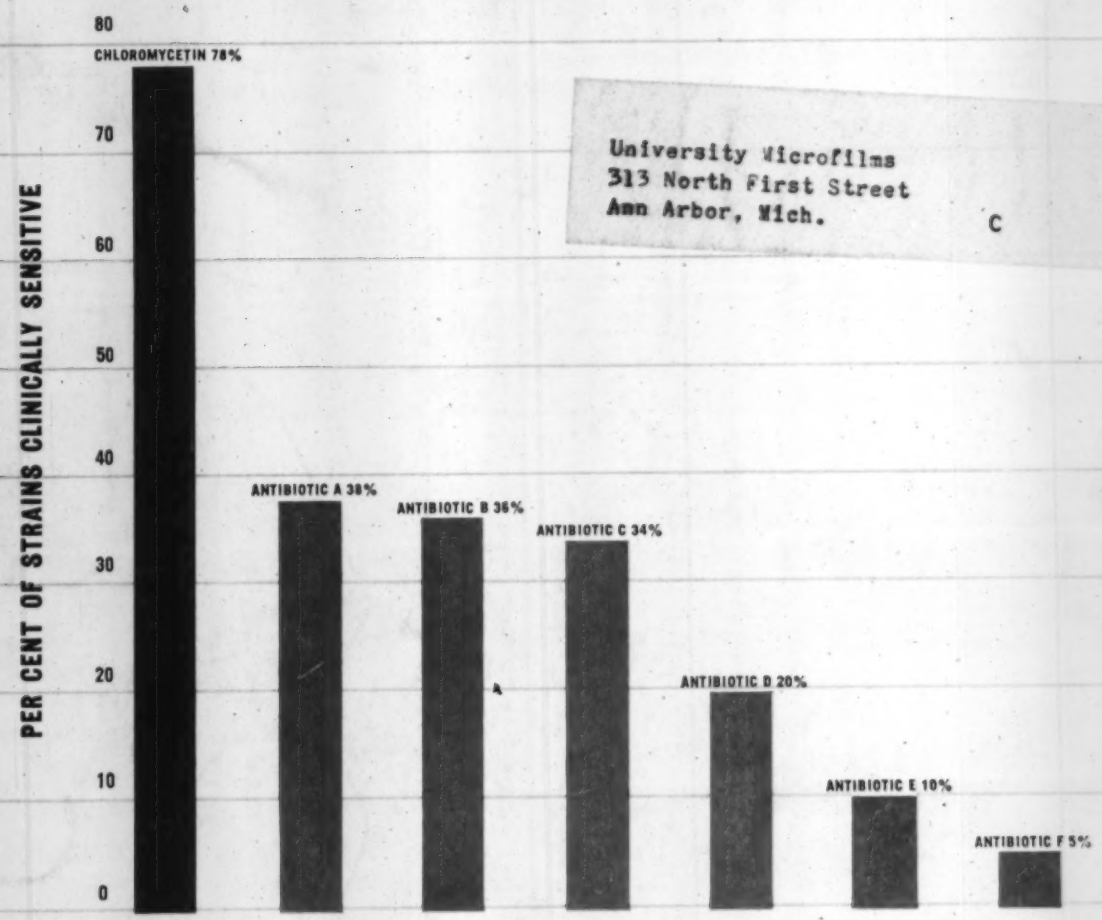

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COMPARATIVE SENSITIVITY OF MIXED PROTEUS SPECIES TO CHLOROMYCETIN AND SIX OTHER WIDELY USED ANTIBIOTIC AGENTS*

*This graph is adapted from Waisbren, B. A., & Strelitzer, C. L.: *Arch. Int. Med.* 99:744, 1957. It represents *in vitro* data obtained with strains isolated from patients between the years 1951 and 1956. Inhibitory concentrations, ranging from 3 to 25 mcg. per ml., were selected on the basis of usual clinical sensitivity.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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